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ABSTRACT

The oral testimony of health professionals recorded in this document questions the Federal government's success at assuring prenatal care for poor women. The concern is that many of the infant deaths that occur in the United States might be prevented if the mother had received adequate prenatal care. Programs have improved the health care delivery for many women but the country lags behind gains made in other industrialized nations, and the mortality rates for black infants has actually increased. Barriers to prenatal care include the following: (1) inadequate family income; (2) stress of day-to-day survival; (3) lack of transportation to clinics; (4) lack of knowledge of the pregnancy; (5) inability to communicate with health care providers; and (6) the mother's perception that the care is not useful, supportive, or pleasant. Written statements and letters are also included. Descriptions of programs and new proposals for services and research are presented. Statistical data are presented in tables. Three appendices clarify the testimony. (VM)

INFANTS AT RISK: IS THE FEDERAL GOVERNMENT ASSURING PRENATAL CARE FOR POOR WOMEN?

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON GOVERNMENT OPERATIONS HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

SEPTEMBER 30, 1987

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CONTENTS

APPENDIXES

INFANTS AT RISK: IS THE FEDERAL GOVERNMENT ASSURING PRENATAL CARE FOR POOR WOMEN?

WEDNESDAY, SEPTEMBER 30, 1987

HOUSE OF REPRESENTATIVES,
HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:37 a.m., in room 2154, Rayburn House Office Building, Hon. Ted Weiss (chairman of the subcommittee) presiding.

Present: Representatives Ted Weiss, Nancy Pelosi, and Jim Lightfoot.

Also present: James R. Gottlieb, staff director; Diana M. Zuckerman, professional staff member; Gwendolyn S. McFadden, secretary; and Mary Vihstadt, minority professional staff, Committee on Government Operations.

OPENING STATEMENT OF CHAIRMAN WEISS

Mr. WEISS. Good morning. The Human Resources and Intergovernmental Relations Subcommittee is now in session.

Every year, approximately 40,000 infants born in the United States die before their first birthday. This represents more than 1 percent of all babies born in our country. Many of these deaths could have been prevented if their mothers had received adequate prenatal care. Today's hearing will examine the Federal programs that support health care during pregnancy to determine how they could do more to ensure the health and survival of our Nation's children.

In 1980, only approximately 80 percent of white women and 60 percent of minority women obtained health care during their first trimester of pregnancy. The U.S. Surgeon General set a goal that by 1990, 90 percent of all pregnant women in the United States, regardless of race, would obtain prenatal care during the first trimester of pregnancy.

What progress has been made since then? As of 1985, the latest statistics available, the numbers are almost identical to 1980. Only approximately 80 percent of white women and only 60 percent of minority women receive prenatal care during the first 3 months of pregnancy. There have been very small improvements for white women, Hispanic women and Native Americans, but the situation has deteriorated slightly for black women.

Since prenatal care is the single most important factor preventing infant mortality, it is not surprising that our country's progress regarding infant mortality has also come to a virtual halt. The terrible truth is that infant mortality may even be increasing in the United States. Meanwhile, other countries have continued to successfully fight infant mortality. In the 1950's, the United States was sixth among 20 industrialized nations in infant mortality. Now the United States is tied for last place among the same 20 industrialized nations.

The purpose of today's hearing is to examine why the United States, which has the greatest health care available in the world for some people, has unsuccessfully struggled against a national tragedy of 40,000 infants dying every year.

The findings of two major studies of pregnant women will be released for the first time at our hearing today. One study, conducted by the General Accounting Office at my request, interviewed uninsured and Medicaid-eligible women across the United States and found that almost two-thirds did not receive adequate prenatal care. A second study of women in 10 States, conducted by Dr. Charles Johnson, found that a surprisingly large number of poor women have no insurance or Medicaid coverage to pay for health care during pregnancy. These are very important studies, and I look forward to hearing about them from our distinguished witnesses this morning.

I also look forward to hearing from our distinguished panelists representing the Institute of Medicine, the National Council of Negro Women, the Children's Defense Fund, and the State of Massachusetts. They will discuss the cost-effectiveness of prenatal care programs and their experiences with such programs, many of which receive Federal funds.

Our administration witnesses will discuss the Federal programs that are designed to help pregnant women, focusing on Medicaid and the Maternal and Child Health Services block grant.

Perhaps most important, we will hear the personal experiences of women who have themselves had difficulty in obtaining prenatal care.

Our hearing will attempt to answer the following questions: (1) Why has no progress been made in improving access to prenatal care and preventing infant mortality since 1980; (2) will the recent changes in the Medicaid program help improve this situation by 1990; and (3) is the Maternal and Child Health Services block grant adequately funded to provide essential prenatal services?

I am pleased to note that we have a number of our members with us, and as the day goes on, because of business on the floor, I am sure that we will be joined by other members and others will have to leave, depending on schedules.

At this time, I am pleased to yield to our distinguished ranking member, Mr. Lightfoot.

Mr. LIGHTFOOT. Thank you, Mr. Chairman.

I would like to commend you for calling this hearing to examine access to prenatal care among the uninsured and Medicaid-eligible women. I think it is an important topic given the role adequate prenatal care plays in helping to prevent low birthweight babies and infant mortality.

Although infant mortality rates continue to decline in this country, several disturbing trends are evident. You mentioned this earlier. For example, we no longer have the large decreases in infant mortality rates that we enjoyed in past years. And in some cases, rates are actually increasing among certain segments of the population and certain regions of the country.

Medicaid expansions and increased appropriations for the Maternal and Child Health block grant are two efforts which should help make sure that pregnant women have access to prenatal care services. However, increased Federal spending for programs is not necessarily the entire answer to the problem. Examination of the barriers to receiving prenatal care among poor and uninsured women and methods to overcome these obstacles are most important.

Furthermore, coordination among Federal, State, local, and private sector programs is essential if we are to provide the best and the most complete services to at-risk women.

Testimony from today's witnesses should provide us with some insight into whether Medicaid-eligible and uninsured women have access to prenatal care services. I look forward to hearing this testimony and any recommendations that the witnesses might have for us.

And thank you, Mr. Chairman, for calling this very important hearing.

Mr. WEISS. Thank you very much, Mr. Lightfoot.

We are pleased to announce that today for the first time Ms. Pelosi is an official member of this subcommittee. We welcome you and are pleased to call on you for your opening comments.

Ms. PELOSI. Thank you, Mr. Chairman.

I, too, want to join our colleague, Mr. Lightfoot, in congratulating and commending you for calling this hearing. I endorse what both of you have said, of course, and ask unanimous consent that an extension of my remarks be placed in the record.

Mr. WEISS. Without objection.

Ms. PELOSI. Thank you, Mr. Chairman.

[The opening statement of Ms. Pelosi follows:]

NANCY PELOSI
5TH DISTRICT, CALIFORNIA

1023 LONGWORTH BUILDING
WASHINGTON, DC 20515-0505
(202) 225-4965

DISTRICT OFFICE:
FEDERAL BUILDING
450 GOLDEN GATE AVENUE
SAN FRANCISCO, CA 94102-3490
(415) 556-4862

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GOVERNMENT OPERATIONS

Congress of the United States
House of Representatives
Washington, DC 20515-0505

September 30, 1987

Congressional Oversight Hearing By the
Human Resources and Intergovernmental Relations Subcommittee

Statement of the Honorable Nancy Pelosi on
Prenatal Care for Poor Pregnant Women

THANK YOU MR. CHAIRMAN, I AM PLEASED TO PARTICIPATE IN THIS HEARING TODAY AS A MEMBER FORMALLY NAMED TO THIS IMPORTANT SUBCOMMITTEE.

I LOOK FORWARD TO HEARING THE GENERAL ACCOUNTING OFFICE'S REPORT ON THE USE OF PRENATAL CARE BY MEDICAID RECIPIENTS AND UNINSURED WOMEN.

I FIND THE PERCENTAGE OF ANNUAL INFANT DEATHS IN THIS COUNTRY FRIGHTENING. WHAT MAKES THE PERCENTAGE EVEN MORE ALARMING IS THAT MANY OF THE DEATHS COULD HAVE BEEN PREVENTED BY PRENATAL CARE.

THE OPPORTUNITY FOR PROPER PRENATAL HEALTH CARE AND EDUCATION SHOULD BE AVAILABLE FOR ALL, NOT ONLY FOR THOSE WHO ARE FORTUNATE ENOUGH TO HAVE AN INCOME TO PAY FOR IT. PROVIDING GOOD PRENATAL CARE AND EDUCATION ARE COST-EFFECTIVE MEASURES. IF WE CAN ENSURE THAT INFANTS ARE GIVEN THE STRONGEST POSSIBLE START IN LIFE, OUR SOCIETY WILL BENEFIT AS THOSE INFANTS GROW UP. SURELY GIVEN FEDERAL PROGRAMS SUCH AS MEDICAID AND MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANTS, SOMETHING CAN BE DONE TO RECTIFY THE TRAGIC PROBLEM OF POOR WOMEN WHO REQUIRE MEDICAL CARE BEFORE THEIR BABY IS BORN.

I HOPE THE GAO'S REPORT AND TESTIMONY FROM WITNESSES TODAY WILL DIRECT US TO SOLUTIONS TO THIS NATIONAL PROBLEM.

Ms. PELOSI. I do want to say that as the mother of five children, I can speak firsthand on this subject. And I believe that this is not only the right thing for us to do, it is also the most cost-effective measure we can take in providing for the future of these children.

So, I look forward to the hearing today and again thank you as a mother for calling it.

Mr. WEISS. Thank you very much, Ms. Pelosi.

As is the custom of the Government Operations Committee, all of our witnesses will be sworn in. From time to time during the hearing, we will be inserting into the record, without objection, documents relevant to this hearing.

Before we begin, let me say to all the witnesses who will be appearing that the full text of all their statements will appear in the hearing record, but because of the long list of witnesses today, we are asking all of the witnesses to summarize testimony in about 5 minutes.

There will be time for questions after each panel's presentation. We will also be conforming to the 5-minute rule for questions by each member of the subcommittee during the first three panels, and this will insure that the administration witnesses will have adequate time to testify also.

Before we begin with our first panel, I would like to enter into the record, without objection, a statement from the Honorable Lawton Chiles. Senator Chiles is the distinguished Chairman of the National Commission to Prevent Infant Mortality. I strongly support their efforts and am very pleased that he has taken the opportunity to share his concerns with us.

[The prepared statement of Mr. Chiles follows:]

National Commission to Prevent Infant Mortality
Switzer Building • Room 2006
330 C Street, S.W. • Washington, D.C. 20201
202-472-1364

STATEMENT OF SENATOR LAWTON CHILES

Mr. Chairman and members of the Suboommittee, as Chairman of the National Commission to Prevent Infant Mortality, I appreciate the opportunity to share with you today my concerns and hopes for a most important and yet so vulnerable group of Americans, tiny infants.

With the establishment of the Commission on July 1 of this year, Congress has for the first time given focused and serious attention to the issues of infant health. The Commission has been charged with putting together a national plan for reducing infant mortality in the United States, and our report to Congress and the President is due within one year.

As Chairman of the Commission, I am joined by 3 other Members of Congress: the Commission's Vice Chairman, Representative J. Roy Rowland, Representative Tom Tauke, and Senator Dave Durenberger. Other members of the Commission include Dr. Otis Bowen, Secretary of Health and Human Services, Mr. Charles Bowsher, Comptroller General of the United States, Governor James Thompson of Illinois and other state government officials, plus maternal and child health experts.

Mr. Chairman, although our infant mortality rate has markedly improved over the past few decades, that progress has come to a virtual standstill in recent years. Today, nearly 11 out of

every 1000 infants born each year in the United States die before their first birthday. That translates into over 40,000 infant deaths per year or 110 per day. And what's most tragic is that so many of these deaths are preventable.

In my home state of Florida, we are making progress, but the infant mortality rate is still higher than the national average, and nearly twice as many black infants die as do white infants.

In a country such as ours that prides itself in having the most advanced health care system in the world, this situation is unconscionable. Indeed, the United States, which ranked sixth internationally in the early 1950's, now ranks seventeenth among industrialized countries.

Numerous national and regional studies have documented the causes of infant mortality and have offered some fairly straightforward recommendations to solve the problem. The main cause of infant death is low birth weight; babies born so small that they don't survive or must spend their first few months of life in expensive newborn intensive care units. And low birth weight babies that do survive run a significantly higher risk of lifelong mental and physical disabilities.

So how do we assure that babies are born at a healthy weight? It's quite clear. The mother must receive adequate, comprehensive prenatal care starting early in her pregnancy. It is such a simple sounding solution, yet it has remained an elusive goal in this country. Many women do not get the care they need, particularly those with low incomes, minorities, and

teenagers - the very individuals who are at the highest risk of having a low birth weight baby.

While we don't have all the answers about why babies die, we do know enough to prevent a substantial number of these deaths. Solutions involve both health and social strategies, filling in the gaps in existing programs and services for pregnant women and infants, and finding ways to better coordinate and organize these programs and services. But to turn this knowledge into reality, we first need the societal commitment and political will to make it all work. Government can't do it alone, nor can the private sector. The National Commission to Prevent Infant Mortality will be holding public hearings and meetings across the country to bring the problems and also the solutions to the attention of public policymakers and private sector leaders.

It is time for action, Mr. Chairman. We all have a stake in this and an important role to play. Our children are our future. I thank you again for this opportunity to share my thoughts with you.

Mr. WEISS. Let me now welcome our first panel of witnesses and ask them to come to the witness table as I call their names. They are Denise Ferrell from Washington, DC; Sherrilyn Longacker from Nassau, NY; Dr. Dorothy Height of the National Council of Negro Women was scheduled to testify, but she is ill today and Ms. Bass will represent that agency; and Dana Hughes, senior health specialist from the Children's Defense Fund.

Will you take your positions behind the chairs where your nameplates are located.

Would you all stand? Raise your right hands.

Do you affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

Let the record indicate that each of the witnesses has answered in the affirmative.

Now, let me tell you also that we have a new sound system which is supposed to make things better and easier. However, there is always a period of adjustment. So, I am not sure how it is going to work. The one thing I do know is that you have to speak directly into the larger of the two microphones that are in front of you, because if you move away from it, it does not pick up the voice. It is totally voice activated. That is why you hear my voice fading in and out from time to time, because I forget.

I want to thank all of you for joining us today. And I know that for a number of you it has been a difficult thing to move your schedules and arrange them so that you could be with us. And in some instances, it was a difficult trip to get here as well. So, we appreciate it.

Ms. Ferrell, let's start with you, all right? Will you pull one of those microphones right in front of you? There you go.

Would you introduce yourself, and tell us who you are, a little bit about yourself, and then tell us what you think we ought to be hearing from you.

STATEMENT OF DENISE FERRELL, WASHINGTON, DC

Ms. FERRELL. My name is Denise Ferrell.

Mr. WEISS. Again, move the larger of the microphones right in front of you and speak up loudly. There you go.

Ms. FERRELL. My name is Denise Ferrell, and I live in Washington, DC.

In January of this year, I applied for Medicaid. Before I went, I called and got the information on what papers I should bring in. I brought in those papers. They gave me other papers to bring in, and when I called them back, I talked to Mr. Upton. He said that he could not find all the papers that I brought in, so, I had to go back to him. He gave me a date to come in. I went back and gave him the papers again. I also gave him the xerox copies of the papers I had given him before—of the originals. And then he said he would get back to me and let me know whether or not I was accepted for Medicaid. He never called me back. I received a letter in the mail saying that I was over income.

And then they gave me a man to talk to—I think a Mr. Butz. And I talked to him for a while. He had me go to 500 First Street, Northwest. I talked to two social workers there, and they had me

go back to Mr. Upton, bring him some more papers, some statements from people in the neighborhood and whatnot. And then he let me know that I was over income.

I felt that while I was at the office, he could have let me know that I was over income instead of sending it in the mail and treating me like I was a number and not a person. When you go down there, you pick out a number. They do not use your name unless they have to. They go, oh, you're No. 21. And then they say, OK, you're No. 21, I meant to call the No. 19. Could you go back over there and sit down? And you sit down and they call your name and you're waiting on the number.

All they have to do is tell me you're over income by *X* number of dollars. They told me I was over income by $1,400. If I could bring in statements or bills for $1,400 or more within a 3-month period—February, March, and April—showing that I had not paid them, I could get Medicaid. But, if I had $1,400, I could pay the $1,400 that I owe and maybe I wouldn't need Medicaid. They don't ask you any of that stuff. They just go numbers and figures.

Mr. WEISS. And do you want to tell us a little bit about when you gave birth and what kind of care you received during the time that you were awaiting birth?

Ms. FERRELL. During the time that I was waiting to figure out whether or not I would eventually get Medicaid, I was paying my doctor, Dr. Niles, as I went to him. Sometimes I didn't have the money, and he let me pay later, which I paid him. And then I got Medicaid in July, and I delivered July 15. So, I got Medicaid in time enough to pay for the delivery at the hospital, but in between those times, I did the paying myself.

Mr. WEISS. So, the doctor who took care of you helped you to get your Medicaid benefits?

Ms. FERRELL. Yes. I feel the only reason that I got it is because he talked to—I think the man's name was Mr. Butz. He talked to him. In between all that time, they just said, no, I couldn't get it, and I was over income.

Mr. WEISS. So, you were able to negotiate the system because you received help from your personal doctor. Is that right?

Ms. FERRELL. My personal doctor, yes.

Mr. WEISS. OK. Thank you very much.

Ms. Longacker, we will now hear your testimony. Again, pull the microphone very close to you.

STATEMENT OF SHERRILYN LONGACKER, NASSAU, NY

Ms. LONGACKER. Good morning. My name is Sherrilyn Longacker. I live in Nassau, NY, which is a small, rural town in Rensselaer County, 17 miles east of Albany, the New York State capital.

I am here today to tell you how hard it is for low-income people who don't qualify for Medicaid to obtain medical care, especially women who need prenatal care.

I am married and have three children: Lisa, 18; Damien, 10; and Lucas, 9. I have come to tell you about the birth of Lucas, my youngest, because I believe that no mother-to-be should go through what I went through, an entire pregnancy without prenatal care.

When I was pregnant with Lucas, we lived in Catskill, NY, in Greene County, about 35 miles south of Albany. Soon after I learned I was pregnant, the company where my husband worked was sold and he lost his job. Our family of four had to survive on my husband's $85-a-week unemployment benefit. We had to sell our home because we couldn't keep up the payments.

I applied for Medicaid in Catskill and was denied because my husband's unemployment put us over the eligibility guidelines. Purchasing private health insurance was financially out of the question. I could not afford gas to drive to Albany, 35 miles away, where the only clinic was located. Our car was unreliable, and we could not afford repairs. No public transportation was available.

During my entire pregnancy with Lucas, I received no prenatal care. When I went into labor, I went into the emergency room at a local hospital and gave birth. Fortunately he was born a healthy baby, but he has a learning disability, and I will never know if it is related to my lack of prenatal care.

You may be saying to yourself what happened to me happened 9 years ago, and that things must be better now. That simply isn't true. For the last 7 months my husband and I were on public assistance. We had full Medicaid and we did not have to worry about the high cost of medical care.

This month my husband went back to work as a subcontractor for a home improvement company. In a good week he grosses over $300, but he has to pay his own taxes, Social Security, gas, tools. The money he brings home puts us well over the Medicaid eligibility guidelines, but doesn't leave us enough money to pay for health insurance.

I called our local Blue Cross/Blue Shield, and the cheapest policy is $1,200 to $1,500 a year. I just hope that my family and I stay healthy until we can afford health insurance.

The irony of our situation is that if we were back on welfare, we would have better health benefits than we have now.

If I were pregnant now again, I could not afford prenatal care.

Americans should not have to be on public assistance to obtain health care. Low income, working Americans should not have to live in fear that they cannot afford prenatal care or any other care. Our children are America's future. It is in everyone's best interest that they do not go without prenatal care.

Thank you.

Mr. WEISS. Thank you very much.

Ms. Bass, we will now hear from you. I am going to ask again formally to please extend our best wishes to Dr. Height.

STATEMENT OF LINDA E. BASS, DIRECTOR OF HEALTH PROGRAMS, NATIONAL COUNCIL OF NEGRO WOMEN

Ms. BASS. Thank you.

Mr. Chairman and distinguished members of your subcommittee, my name is Linda Bass, and I am a staff member of the National Council of Negro Women, which is a coalition of 32 national organizations with 220 community-based sections and an outreach to as many as 4 million women.

As I have said, I am here today representing Dr. Dorothy Height who could not be here today to present this testimony. I want to thank you on behalf of Dr. Height and NCNW for the opportunity to speak about this critical matter.

The National Council of Negro Women has had for many years experience working in communities across the country on the problem of teen pregnancy and other issues pertaining to preventive health care such as immunization of poor and medically underserved black families. We know that access to health care among the poor and working poor has historically been inadequate. As a result, in black America common health problems become serious health threats. In the words of Rev. Joseph Lowery, "When America has a cold, the black community has pneumonia."

As a result of little or no prenatal care, especially among poor, teenage black mothers, thousands of babies are being condemned to death or lifelong disability. The great travesty of this lies in the proven fact that early prenatal care does reduce the incidence of infant mortality, low birthweight, birth defects, and neonatal mortality.

When we talk about the reasons or barriers to health care and prenatal care in particular, we commonly speak about cultural and institutional barriers and to the devastating effects of poverty. For poor black and other minority women, this translates to lack of education, inadequate family income, lack of transportation, and the stress of day-to-day survival struggles just to house and feed families with little support from a husband, father, or other community support systems.

Underutilization of the health care services which do exist may be a result of health care practices which fail to address the comprehensive needs of these women. And this may well be an underestimated factor which ranks up with the problem of inadequate finances, insurance, and other means to pay for health care.

We have learned from experience that health must be addressed within the context of the whole person because health in and of itself is not a priority when compared to basic needs to such as food and shelter and other daily survival needs. We have seen that in communities with community health centers and maternal infant projects which stress outreach to high risk mothers and which address the range of needs, including counseling on the hazards of cigarette smoking, drug use and alcohol consumption, which gives genetic screening and counseling, which stress education on nutrition, delivery, breastfeeding and parenting, and counseling and enrollment in appropriate programs, such as Medicaid and Aid to Families with Dependent Children, there is a better use of the services and resulting decreases in infant mortality.

Along these lines, the type of prenatal care provider serving poor and high risk mothers is as significant as are the pregnant woman's perception of whether care is useful, supportive and pleasant. We know that some poor women, especially minority women, fail to seek prenatal care early because of lack of knowledge and information about their pregnancy, because of language barriers and because of inability to communicate satisfactorily with traditional health care providers.

More use of certified nurse midwives and obstetrical nurse practitioners who tend to relate in a nonauthoritarian manner and who emphasize education, support, and patient's well-being is of great importance to the improved access to prenatal care.

Issues of financial barriers and what can be done present, in our view, an opportunity for progress. For poor women the Medicaid program is a key part of the assurance of access to prenatal care——

Mr. WEISS. Ms. Bass, that mike is giving you problems too. Would you push it away from you just a little bit? There you go.

Ms. BASS [continuing]. Is a key part of assurance of access to prenatal care and subsequent reduction in low birthweight and neonatal death and disability.

Medicaid policies and reimbursements should reflect the high risk nature of the Medicaid-eligible population. And eligibility standards should be expanded to maximize the possibility that poor women qualify for the coverage.

In spite of their state of poverty, many poor and low income women do not prefer to accept services at no cost.

We are pleased with the SOBRA Medicaid amendments and the infant mortality amendments of 1987 which help address the financial barriers to prenatal care.

Finally, we are pleased to be working in collaboration with the March of Dimes and the Children's Defense Fund, both of whom share our concerns and whose interest in access to prenatal care stems from their efforts to reduce the incidence of low birthweight.

We supported the Medicaid infant mortality amendments contained in SOBRA.

So, in closing, Mr. Chairman, I wish to thank you again for this opportunity to present some of the views of the National Council of Negro Women.

[The prepared statement of Dr. Height follows:]

BASS

TESTIMONY BY

DOROTHY I. HEIGHT
PRESIDENT, NATIONAL COUNCIL OF NEGRO WOMEN
CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
HOUSE GOVERNMENT OPERATIONS SUBCOMMITTEE
on
HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS
2203 Rayburn House Office Building
WASHINGTON, D.C. 20515
Sept. 30, 1987

Mr. Chair, the Honorable Ted Weiss, and distinguished members of the House Government Operations Subcommittee on Human Resources & Intergovernmental Relations. I am Linda Bass, staff member of the National Council of Negro Women, a coalition of 32 national organizations with 220 community-based sections and an outreach to as many as four million women. I am here today representing Dr. Dorothy I. Height, National President of the National Council of Negro W[illegible] who could not be here today to present this testimony on the matter of access to prenatal care. I want to thank you on behalf of Dr. Height and NCNW for the opportunity to speak about the critical matter particularly of Black women's access to prenatal care.

The National Council of Negro Women has had many years of experience working in communities across the country on the problem of teen pregnancy and on other issues pertaining to preventive health care such as immunization of poor and medically underserved Black families.We know that access to health care among the poor and working poor has historically been inadequate. As a result, in Black America, common health problems become

serious health threats. In the words of Rev. Joseph Lowery,"when America has a cold, the Black community has pneumonia."

As a result of little or no prenatal care especially among poor, teenage Black mothers thousands of babies are being condemned to death or lifelong disability.The great travesty of this lies in the proven fact that early prenatal care does reduce the incidence of infant mortality, low birthweight, birth defects and neonatal mortality.

Reference to the reasons or barriers to health care and prenatal care in particular most commonly speak to the cultural and institutional barriers, and to the devastating effects of poverty. For poor Black and other minority women, this translates to lack of education, inadequate family income,lack of transportation, and the stress of day-to-day survival struggles to house and feed families with little support from a husband, father or other community support systems. Underutilization of health care services as a result of health care practices which fail to address the comprehensive needs of these women may well be an underestimated factor which ranks up with the problem of inadequate finances, insurance and other means to pay for health care.

We have learned from experience that health must be addressed within the context of the whole person because health in and of itself is not a priority when compared to basic needs such as food and shelter and other daily survival needs. We have seen that in communities with community health centers, and maternal infant projects which stress outreach to high-risk

mothers and which address the range of needs including counseling on the hazards of cigarette smoking, drug use and alchohol consumption, genetic screening and counseling, education on nutrition, delivery, breast-feeding and parenting, and counseling and enrollment in appropiate programs such as Medicaid and Aid to F milies with Dependent Children, there is better use of the services and resulting decreases in infant mortality. Along these lines, the type of prenatal care provider serving poor and high-risk mothers is as significant as are the pregnant womans' perception of whether care is useful, supportive and pleasant. We know that some poor women especially minority women may fail to seek prenatal care early because of lack of knowledge and information about their pregnancy, because of language barriers and because of inability to communicate satisfactorily with traditional health care providers. More use of certified nurse-midwives, and obstetrical nurse practitioners who tend to relate in a nonauthoritarian manner and to emphasize education, support and overall relate to patient's well-being is of great importance to the improved access to prenatal care.

The issues of financial barriers and what can be done presents in our view, an opportunity for progress. For poor women, the Medicaid program is a key part of the assurance of access to prenatal care and subsequent reduction in low-birthweight and neonatal death and disability. Medicaid policies and reimbursements should reflect the high-risk nature of the Medicaid-eligible population, and eligibility standards should be expanded to maximize the possibility that poor women

can qualify for the coverage and thus be able to pay for prenatal care. In spite of their state of poverty, many poor and low-income women do not prefer to accept services at no cost. We are pleased with the "SOBRA" Medicaid Amendments and the Infant Mortality Amendments of 1987 which help address the financial barriers to prenatal care by allowing states to increase Medicaid income eligibility for pregnant women and children under 2 up to 100% of the federal poverty level and S. 422 and H.R. 1018 introduced by Chairman Henry Waxman and Senator Bill Bradley allows states to raise Medicaid income elgibility to 185% of the federal poverty level for pregnant women and infants.

Finally, we are especially pleased to be working in collaboration with the March of Dimes and the Children's Defense Fund,both whom share our concerns and whose interest in access to prenatal care stems from their efforts to reduce the incidence of low-birthweight. We supported the Medicaid Infant Mortality Amendments contained in SOBRA.

In closing, I wish to again thank you Mr. Chairman for this opportunity to bring to this hearing some of the views of the National Council of Negro Women.

Mr. WEISS. Thank you very much, Ms. Bass.
Ms. Hughes.

STATEMENT OF DANA HUGHES, SENIOR HEALTH SPECIALIST, CHILDREN'S DEFENSE FUND

Ms. HUGHES. Mr. Chairman and members of the subcommittee, the Children's Defense Fund is pleased to have this opportunity to address you today.

CDF, as you may know, is the national public charity which engages in research and advocacy on behalf of the Nation's low income and minority children. For 15 years, CDF's health division has been involved in extensive efforts to improve poor children's and pregnant women's access to medically necessary health care, including prenatal care and risk appropriate labor and delivery services.

We applaud you for holding these hearings to draw attention to the need for improved access to prenatal care.

I have prepared written testimony which has been submitted for the record, and I request the opportunity to leave the record open to submit additional comments later if I may.

Mr. WEISS. Without objection, that will be done.

Ms. HUGHES. Because of my testimony's length, what I would like to do is to highlight some of the key findings at this time.

Mr. WEISS. That's good.

Ms. HUGHES. I would like to begin with two brief stories.

Ollie Hill gave birth to a 4½ pound baby last June in Detroit. Because of her daughter's small size, Ms. Hill's infant had to be hospitalized for several days, many of those in a neonatal intensive care unit. Ms. Hill, who was uninsured and unemployed, received no prenatal care during her pregnancy. When she was asked why she didn't receive care, Ms. Hill responded that the primary reason was because she had no money to pay for a doctor's care. If she had received care, the chances that her baby would have been born at low birthweight would have been dramatically reduced.

Sharon Ford, who was enrolled in a prepaid health plan in California, went into the closest hospital when she went into labor last year. However, because she didn't have documentation of her health insurance and the hospital lacked documentation as well, she was denied access to care.

Because she was in labor, Ms. Hill sought care in the next closest hospital, only to be told again that since she had no documentation of her insurance status, she would have to go elsewhere for care. In this case though, the hospital gave her a test to determine the condition of her baby. Although they found that the baby was in distress they nonetheless transferred Sharon Ford to a public hospital where her baby was delivered stillborn.

Unfortunately, these are not isolated cases. In 1985, more than three-quarters of a million babies were born in this country to mothers who did not receive prenatal care during the first 3 months of pregnancy, the time when medical experts believe that it is essential that prenatal care begin.

And 1985 was also the sixth consecutive year in which the Nation's record worsened or failed to improve in terms of the propor-

tion of babies born to mothers who receive either no prenatal care or care that doesn't begin until the last 3 months of pregnancy.

Among black infants the problem is particularly grave. In 1985 the percentage of babies born to mothers who received late or no prenatal care at all jumped from 9.6 percent to 10.3 percent. This means that more than 1 out of every 10 black infants was born to a mother who received either late or no prenatal care.

As we have just heard, the reasons why women don't receive prenatal care are varied, but among poor and minority women the primary barrier is financial inaccessibility.

In 1984, which is the last year for which we have these data, 9.5 million women of child-bearing age had absolutely no health insurance, either private or public. If these women were wealthy, they might have been in a position to purchase their maternity care. However, two-thirds of all of these uninsured women had incomes below 150 percent of the Federal poverty level. Therefore, they clearly were without the means to purchase the maternity care themselves.

Lack of health insurance not only prevents women from obtaining prenatal care, but hospital delivery services as well. Increasingly, hospitals require uninsured women to place sizable deposits before they are permitted to register for services. Frequently these deposits equal the total anticipated charges, and for a high-risk woman, that can easily exceed $3,000, which is clearly an amount that is prohibitive for most families, particularly those with low incomes.

Yet, unless a woman is permitted to preregister for delivery services, the hospital cannot be aware of or prepared for her condition, placing both the mother and the baby at severe risk.

The lack of health insurance and the means to purchase care is a primary barrier preventing low-income women from obtaining care. There are other barriers as well. These include lack of transportation to care, long waiting times before a physician sees the woman, inconvenient clinic hours, long appointment delays and problems getting on public assistance programs, as well as lack of providers who will see low-income women.

Just yesterday I received a call from a community in upstate New York where there was absolutely no obstetrician that would accept a Medicaid-eligible woman. Pregnant women, therefore, were obligated to travel 30 miles away to a nearby hospital if they were to receive prenatal care services. The bus ride costs $12. For many women, the combined effect of a long period, long traveling time, as well as the money required to seek care means that they are unable to obtain care.

Unfortunately, this community's problem is not an isolated situation either. There are many communities where women face problems obtaining existing prenatal care services designed for low-income women.

In Los Angeles County, women must wait as long as 16 weeks before they receive a first prenatal care appointment. A recent survey found that at one clinic a caller was told, "We take appointments one day each month. Call back on the 24th at 8 p.m. There are lots of pregnant women out there, and the appointments go really fast. Just keep calling, calling and calling. You have to real-

ize that that is what you are going to do that day, just like you did today. Make sure you call early because all of the appointments are normally gone by 1 o'clock."

The impact of limited access to care can be devastating as the cases of Sharon Ford and Ollie Hill demonstrate. The magnitude of this impact, however, is enormous.

Mr. WEISS. Ms. Hughes, please pull the microphone just a little bit closer to you. The large one should be closer to you.

Ms. HUGHES. Public health officials and others have expressed concern over the past few years that the Nation's progress in reducing infant mortality has slowed. As mentioned earlier, during the 1970's, the infant mortality rate in this country dropped by an average annual rate of about 4.5 percent. Between 1980 and 1984, that slowed to 3.7 percent.

However, in 1985 according to the National Center for Health Statistics, there was no statistically significant decrease in the infant mortality rate from the 1984 level. That means that we have essentially leveled off at 10.6 deaths for very 1,000 live births while other nations continue to reduce their infant mortality level below 6 and 7 deaths for every 1,000 live births.

The need for removing barriers to prenatal care for low-income women is a longstanding problem. However, this devastating revelation of the dramatic slowing of the infant mortality rate and, in fact, the leveling off, calls for immediate action towards reducing the barriers that exist for poor women.

The Children's Defense Fund has a series of recommendations that we would like to offer the subcommittee. First, we recommend nationwide adoption of the SOBRA option to allow States to raise the income eligibility level up to 100 percent of poverty for pregnant women and infants. To date 25 States have done so. The remaining must do so as well.

Second, we recommend swift enactment of Senate bill 422 and H.R. 1018, the Medicaid infant mortality amendments of 1987 which would permit States to raise the eligibility level to 185 percent of poverty. While it is clear that pregnant women who are Medicaid-eligible often have difficulty obtaining services and finding providers who can accept them, it still remains the most viable vehicle for financing maternity services for pregnant women, and we encourage its use at this time.

We also recommend additional funding for residual programs to ensure the availability of providers in medically underserved areas, primarily the Community Health Center program and the Maternal and Child Health block grant.

Fourth, we recommend enforcement of antidumping provisions from the Consolidated Omnibus Budget Reconciliation Act of 1986. There were changes in the law that prohibit dumping of patients who are in emergency situations which includes women in active labor. Unfortunately, these have not been fully enforced, and as a result, many women continue to be turned away from care. In addition, this law should be extended to prohibit hospitals from refusing hospital-to-hospital transfers of women or infants—for example, a woman or a child from a low-risk hospital to a high-risk hospital.

Finally, we recommend prohibition against preadmission deposits for pregnant women. Hospitals should permit preadmission of all

women regardless of their ability to pay and work out financial arrangements after women have been assured risk appropriate delivery services.

Thank you.

[The prepared statement of Ms. Hughes follows:]

Testimony of the
Children's Defense Fund Before the
Subcommittee on Human Resources and Intergovernmental Relations
Committee on Government Operations
United States House of Representatives
Regarding Access to Prenatal Care

Presented by
Dana Hughes
Senior Health Specialist

September 30, 1987

Mr. Chairman and Distinguished Members of your Subcommittee: The Children's Defense Fund (CDF) is pleased to have this opportunity to testify today regarding access to prenatal care. CDF is a national public charity which engages in research and advocacy on behalf of the nation's low income and minority children. For fifteen years, CDF's health division has been involved in extensive efforts to improve poor children's and pregnant women's access to medically necessary care, including prenatal care and risk-appropriate labor and delivery services. We applaud you for holding this hearing to draw attention to the need for improved access to prenatal care.

My testimony is divided into five parts: I) The Health Status of Infants; II) The Role of Prenatal Care; III) Prenatal Care Trends; IV) Barriers to Prenatal Care; V) Recommendations.

I. The Health Status of Infants

The health status of infants is regarded as the bellweather of overall community health and the extent to which the needs of vulnerable citizens are met. Two of the most telling indicators of infant health are infant mortality and low birthweight. Low birthweight is an especially useful indicator for three reasons. First, infants born at low birthweight are at great risk of health and disability. Low birthweight babies are 20 times more likely to die in their first year and are at 3 times greater risk of having lifelong disabling conditions such as mental retardation, autism, hearing and visual impairments and learning disabilities.[1] Second, low birthweight can often be prevented with early, continuous, high quality prenatal care. Thus, large numbers of low birthweight babies specifically indicate a breakdown in our ability to provide preventive health services. Third, unlike rates of infant mortality, the incidence of low birthweight is not affected by medical technology and other means of sustaining fragile lives. Instead, low birthweight is closely associated with the health of mothers and infants, and therefore truly reflects changes in health status when its incidence changes.

Infant mortality and low birthweight rates in the United States have slowly, but steadily declined since the mid-1960's. However recent trends indicate that progress is dramatically slowing and may have come to a complete halt.

- According to the National Center for Health Statistics, in 1985 there was no measurable decrease in the nation's rate of infant mortality.[2] This follows four years of a general slowing trend in reducing infant mortality compared to earlier years. (Table I) During the 1970's, the nation's infant mortality rate declined by an annual average rate of 4.5 percent per year. Between 1981 and 1985, the rate change dropped to 2.9

percent per year on average.

- It is suggested by some that the recent slowing in the infant mortality rate reduction is an expected phenonenon as the nation's rate approaches a "natural" threshold. However, other countries have managed to reduce their infant mortality rates further and more rapidly over a sustained period of time. Between the period 1950-1955 and 1980-1985, the U.S. infant mortality rate declined by 61 percent. Of 18 other industrialized countries with comparable data collection systems, all had greater rates of improvement, including countries that initially had rates lower than the United States during 1950-1955.

- Because the United States has failed to reduce its rate of infant mortality as rapidly as other countries, the nation's international ranking has deteriorated substantially over the past thirty years. During the 1950-1955 period, the United States ranked sixth best among twenty industrialized countries. By 1980-1985 period, the nation had fallen to a tie for last place among the same countries.[4] (Table II)

- Meanwhile, the incidence of babies born weighing less than 5.5. pounds (those considered to be at low birthweight) has stagnated in recent years. In 1985, the percentage of all babies born at low birthweight actually increased from the 1984 levels.[5] (Table I) This increase represents the first time since 1965 that such an increase has occurred.

II. The Role of Prenatal Care

Some infant deaths and low birthweight births are unavoidable because of limitations to current medical knowledge and technology. However, many deaths and low birthweight births can be prevented through a variety of health and medical interventions. According to the Institute of Medicine, the most effective method of reducing low birthweight and infant deaths associated with low birthweight is by providing pregnant women with early and comprehensive prenatal care services.[6]

Prenatal care influences low birthweight in a number of ways. First, medical conditions that can lead to prematurity or low birthweight can be identified, treated and monitored. Second, health and social risks that have the potential of distrupting infant development, such as smoking and poor nutrition, can be identified and modified through education and counseling. Third, pregnant women can be instructed on how to identify and respond to health problems that require immediate attention, such as preterm labor. Finally, for a woman in need

of social services, prenatal care can serve as the point of referral for nutritional, housing and financial support services that are essential during pregnancy and after the infant's birth.

Prenatal care has a powerful influence on pregnancy outcome, particularly among women who are at social or medical risk.[7] Studies show that high risk women who receive inadequate care are more than twice as likely to have a low birthweight baby than women who receive adequate care.[8,9] Similarly, mothers who receive no prenatal care are more than 3 times more likely to have a preterm baby.[10] Findings with respect to infant mortality are similar. Babies born to mothers who receive inadequate prenatal care are significantly more likely to die in their first year than babies born to mothers who receive adequate care.[11,12] According to the U.S. Public Health services, "More than any other factor, the delay and absence of prenatal care accounts for the high incidence of infant mortality, since health problems can go undetected without prenatal care ... should a mother go without effective care, she will then be three times as likely to bear an underweight baby susceptible to infant mortality, prematurity, mental retardation and malnutrition."[13]

The Institute of Medicine and other experts are persuaded by data that show that babies born to mothers who receive prenatal care are healthier than babies born to mothers who receive none. They are also influenced by the cost effectiveness of prenatal care. The Institute of Medicine found that every dollar invested in prenatal care saves $3.38 in first year costs alone.[14] Other experts estimate that the same dollar saves $11 over the lifetime of the child by averting the need for additional medical treatment, special education and special social services.[15]

III. Trends in Prenatal Care

Despite the importance of prenatal care in preventing low birthweight and infant mortality, nearly 25 percent of all babies are born to mothers who do not begin prenatal care during the first three months of pregnancy, the period within which medical experts consider it essential that care begin. Nearly one-third of all black infants are born to mothers who do not receive early care. (Tables III, and IV)

Recent prenatal care utilization figures are especially alarming because virtually no improvement has been made since 1980 when 76.3 percent of babies were born to mothers who received early care. By 1985, this figure declined to only 76.2 percent. Not only has the nation failed to improve its record, but preratal care utilization is actually getting worse among some populations. In 1985, the percentage of black infants born to women who received early prenatal care declined from 62.2 percent to 61.2 percent. Similarly, the percentage of babies born to mothers who received late or no prenatal care that year

substantially increased from 9.6 percent to 10.3 percent. In other words, more than one out of every ten black infants was born to a mother who did not receive prenatal care until the last three months of pregnancy, or received no care at all. That year marks the first time since 1975 that late or no prenatal care figures among black infants have exceeded 10 percent.[16]

IV. Barriers to Prenatal Care

The reasons why pregnant women do not receive adequate prenatal care are varied. For poor women, however, appropriate prenatal care services are simply not available or accessible. Indeed, poor women face a number of obstacles that can prevent them from obtaining needed care.

FINANCIAL BARRIERS

The most formidable and pervasive of all barriers to care are related to financial inaccessibility. Numerous studies reveal that lack of health insurance and the resources to purchase care directly contribute to low prenatal care utilization.[17,18,19] A review of studies on barriers to access to prenatal care prepared for the Institute of Medicine found that of 21 studies that asked women why prenatal was not obtained, financial barriers were the most commonly sited reason. In fact all but one study found financial barriers to be a measurable or statistically significant factor.[20]

Financial inaccessability to prenatal care results because health services in the United States constitute a commodity that is purchased in the marketplac, just as one might buy groceries or a television. A small amount of prenatal care is provided to low income women free of charge by public and quasi-public providers funded under various federal, state and local authorities. But for most women, including, low income women, maternity care is a service that must be purchased. Thus, access to prenatal care requires that a woman have health insurance, the resources to pay for care out of pocket, or access to free services. For large numbers of women, these conditions are simply not met.

Insurance Coverage: In 1984, 9.5 million women of childbearing age were completely uninsured, both publicly and privately.[21] Of women in age groups with the highest rates of fertility (18-24 years), 25 percent, or 2.1 million women, were uninsured.[22] While more recent insurance data for childbearing age women are not available, experts agree that uninsuredness among the population in general has increased since the early 1980's.

Lack of health insurance is most serious among low income women. Two-thirds of all childbearing-age women without health insurance are poor or near-poor (that is, having incomes below

150 percent of the federal poverty level). [23] (Table V) While maternity care is inexpensive to society, especially when compared to the costs of care for unhealthy infants and children, the costs are prohibative for individuals. In 1984 maternity care, including prenatal, delivery and postpartum medical and hospital services, cost about $3,200 for an uncomplicated delivery and about $5000 for care involving a caesarean section delivery.[24] The cost today is even more. Because of these high costs, buying the services out-of-pocket is not an alternative to insurance coverage for poor and near-poor women.

The impact of uninsuredness and underinsuredness on poor women's access to maternity services is profound. In 1980, women who obtained any prenatal care made 7 visits on average. However, poor women made substantially fewer visits than non-poor women (5.7 vs 7.5), while poor and near-poor women (those with family incomes under 150 percent of the federal poverty level) who had no private health insurance and who depended solely on Medicaid, other sources of funding, and their own resources, made only 5.5 visits. [25] Thus, the absence of third-party financing is strongly associated with the number of visits for prenatal care made by low-income women.

As with prenatal and postnatal care, millions of women face serious underfunding of the hospital portion of maternity care. In 1982, nearly 40 percent of all hospital discharges involving "self pay" or "no charge" patients were related to obstetrical care.[26] Obstetrical care that year accounted for 25 percer of all uncompensated hospital inpatient charges. [27]

Again, poor women are disproportionately affected by these trends. Data from the 1982 National Survey of Family Growth indicate that poor women were disproportionately represented among all families that paid for deliveries exclusively with individual resources that year. While 6.4 percent of deliveries to women with family incomes equal to 300 percent of the poverty level or greater were entirely self-pay, 12.3 percent of deliveries to poor women, or nearly twice as many, were performed on a self-pay basis. Conversely, only 19.4 percent of deliveries involving poor women were paid through private insurance, while 49 percent of deliveries to more affluent women were covered fully by insurance. [28]

In response to the large numbers of women uninsured for maternity services, many hospitals now directly or indirectly refuse to admit uninsured maternity patients. Some hospitals simply refuse care to women who are uninsured. A 1986 survey of state maternal and child health agencies revealed that agency heads in 15 states were aware that women in their states were denied access to hospitals while in active labor. Another 13 knew of pregnant patients being turned away from care while in the early stages of labor. In 6 states, respondants were aware

of "patient dumping" occurring in their states, but the specific populations were not identified. Only 14 states reported that this practice was not a problem in their state.[29]

A less direct method commonly used to deny hospital care to uninsured women is the practice of requiring deposits before permitting women to register or be admitted.[30] Frequently, these deposits equal the total anticipated charges, which for a woman at high risk can exceed $3000. Because a woman fails to have such large amounts of cash at the time of registration, admission is denied. The effect of uninsurdness for delivery services can be devastating. A California woman in labor who sought delivery care at a private, voluntary hospital was denied care because the hospital believed she was uninsured. A second hospital turned her away for the same reason, even after it was determined that the baby was in distress. The baby was delivered at the public hospital, stillborn.[31a]

Even women who are not denied access at the time of delivery but cannot preregister face dangers. Unless a woman is preregistered, her records will not be at the hospital (unless she actually carries them). The hospital, therefore, is neither aware of nor prepared for any health problems or complications, placing both mother and baby at grave risk.

Even women who have health insurance experience difficulty obtaining all needed services. Indeed, both publically and privately-insured women may derive little benefit from their insurance enrollment because the scope of coverage is poor.

Scope of Coverage for Privately Insured Women: Data from the National Medical Care Utilization and Expenditures (NEMCUES) report show that among privately insured women who received any pre or postnatal care in 1980, private insurance paid 33 percent of the charges for the care of women with family incomes below 150 percent of the federal poverty level, 42 percent for women with family incomes between 150 percent and 300 percent of the federal poverty level, and 50 percent for women with incomes over 300 percent of the federal poverty level.[31b] This is true despite the 1978 Pregnancy Discrimination Act which requires most employers to include coverage of maternity care in their plans to the same extent that they cover for other medical care.

At least three factors account for the poor performance of private insurance plans covering low income women. First, many insurance plans offer an inadequate scope and content of care. Data on the content of private plans is sketchy, but what we do know indicates that problems exist. Private health insurance plans normally reimburse for maternity care under three separate methods, including a global fee for prenatal and delivery services, reimbursement for laboratory and prescribed drug fees, and hospital reimbursement.[32a] Many of these plans, however, may

place arbitrary limits on the amount of care they will cover. For example, a plan may limit the number of hospital days covered per year or per spell of illness, and many plans place lifetime maximums on the amount that may be claimed at all. Both limitations could cause severe hardships for women requiring highly specialized, inpatient high-risk management.

A second major limitation on coverage can result from large deductibles and coinsurance. As of 1980, only 6 percent of insurance plan participants held full coverage for hospital room and board charges, and only 20 percent had full coverage for inpatient surgery, the category under which prenatal and delivery care are grouped. [32b] Moreover, persons employed at small firms (which tend to hire lower income workers) also tend to have less generous coverage. In 1980, only 5 percent of persons employed by firms of 20 persons or fewer had full coverage for inpatient surgery, compared to 42 percent in the largest firms. [33] There is evidence, moreover, that employers have increased the size of deductibles and coinsurance in recent years in order to keep costs down. [34]

Third, many insurance plans are in fact indemnity plans, paticularly where medical, as opposed to hospital, benefits are concerned. Some indemnity plans may carry options which permit beneficiaries to assign payments directly to their physicians or other health providers. But physicians may be increasingly unwilling to accept assignment of benefits in lieu of advance payment, for fear that high deductibles and coinsurance will leave them with little or no payment for their services. Moreover, since the majority of insurance plans use global fees to pay providers, [35] a provider would normally be required to wait until most, if not all, services were rendered before payment could be made. The indemnity and post-service payment features of private insurance plans, as well as increasing patient cost-sharing requirements, mean that ostensibly insured poor and near-poor women are effectively disunsured. Many would have to prepay most or all of a medical provider's charges in order to obtain treatment.

Scope of Coverage for Medicaid-Enrolled Women: Medicaid programs, like private insurance, do not always cover all prenatal care services. Although states are required to provide all recipients with some services (including, among others, inpatient and outpatient hospital services, physician and nurse midwife services, and laboratory and x-ray services) they may at their option include coverage for other services. States may, for example, include in their plans services furnished by free-standing clinics, prescribed drugs (which can include vitamins and over-the-counter medications), and preventive services such as health and nutritional counseling. Were a state to incorporate all of these items and services in its Medicaid plan, it would have in place a mechanism for financing for poor women

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the full range of medical and allied health care recommended for low income women.

In spite of the flexibility provided states to offer Medicaid recipients services vital to sound pregnancy management, many state programs do not include coverage for the full complement of needed care. A 30-state survey of Medicaid programs' benefit plans revealed that while many states consider optional services such as risk assessments and nutritional counseling as allowable costs, no additional reimbursement is paid for the services.[36a] Thus, practitioners may provide these important services, but only as a part of the normal prenatal care package they furnish. Yet, without additional compensation for these services, there exists no incentive to include optional services, even to high-risk women for whom enhanced maternity care is essential.

While many states consider optional services "allowable," others do not. Among the most common restrictions are limitations on inpatient hospital services. Inpatient limits carry particularly grave consequences for very high-risk pregnant women who must be hospitalized for extended periods in order to avert a preterm delivery. Of the 30 states responding to the survey, twenty-four indicated that they place some limit on covered inpatient hospital days, including medically necessary obstetrical care. Four states, Louisiana, Mississippi, Oregon, and Tennessee, reported that they set limits of 15 days per year or fewer for covered inpatient care, an amount that can be easily exceeded even prior to delivery by a pregnant woman at high risk of preterm delivery. None of these states indicated that they make any exceptions to this rule, even in the case of a high-risk pregnancy. Such limits could conceivably serve as a powerful deterrent to the admission of particularly complex, high-risk pregnancies requiring extensive inpatient treatment. Other coverage limitations imposed by some states include limits on laboratory and x-ray services and prescribed drugs.

The Availability of Free Services: Low income, uninsured patients have few service options available to them. In some communities, clinic services are available at free or income-adjusted rates. A 50 state survey of state maternal and child health agencies revealed that most (48) reported the availability of some free or low cost prenatal care services in their states funded by a combination of Title V (Maternal and Child Health Block Grant), State and local funds. However, due to limited funding levels, services in most states reached only a fraction of the women in need.[36b] Today only four states, Massachusetts, Michigan, Rhode Island and Minnesota, have truly state-wide prenatal care programs for low income women and Rhode Island and Minnesota's programs are not yet operational. Only 23 states finance delivery services for low income, uninsured women. (Under federal law, Title V Maternal and Child Health Block Grant

Funds may not be used to finance delivery services except in high risk women.)

Even when free and income services are available, women can face barriers obtaining them. In the District of Columbia, pregnant women were not, until recently, routinely informed that prenatal care services were available to poor women free of charge. Instead they were billed the full charges for services until they were turned down by Medicaid and then permitted to apply for services under the sliding fee scale. In New York state, prenatal care services are available to uninsured pregnant women with incomes below 185 percent of the federal poverty level, if the qualifying women reside in a community awarded a special grant by the state. While grants were awarded based in part on relative need many communities with large numbers of uninsured pregnant women are without services from the state's prenatal care program. Deliberate and unintential efforts to limit use of free prenatal care services occur in virtually every state.

The availability of free and reduced cost prenatal care has always been severely restricted in this country. In recent years, however, the availability has declined further due to reduced funding for key maternal and child health services on the federal and state level, a growing number of women who require free or subsidized care and rising costs of furnishing health care. In 1981, funds for the Maternal and Child Health Block Grant program were, for example, cut by 18 percent. As a result, 20 states eliminated or reduced health services for pregnant women and children. The community health center program, which provides primary health care services to persons residing in medically underserved areas, received a 13 percent funding cut that year which led to service reductions. A study of obstetrical visits to a community health center in Boston found that visits declined by 14 percent after these cuts, even with a 4 percent increase in births.[36c]

NON-FINANCIAL BARRIERS

Although financial barriers pose the most common and difficult obstacles to care, prenatal care utilization is impeded by other barriers unrelated to insurance coverage. While many of these barriers are related to, if not the result of poverty, they are distinguished from financial barriers in that they cannot be resolved simply by furnishing pregnant women with insurance. These barriers can nonetheless prevent or discourage prenatal care utilization.

Maldistribution of Providers: The United States enjoys more physicians per capita than any other country, yet some communities do not have enough physicians to meet all need, and others have no physicians at all. In New York state, for

example, thee are 220 physicians per 100,000 persons compared to only 80 physicians per 100,000 in Mississippi. The national average is 140 physicians per 100,000 individuals. There are over 5,000 communities, mostly rural, in the U.S. without a doctor. [37]

Maldistribution of physicians occurs largely because physicians may locate their practices based on their own preferences and needs, rather than national or community need. Rural areas are often considered to be less desirable choices because low density can mean that there is an insufficient number of patients to support a full practice. Poor communities are less desirable because low income families frequently cannot afford the fees physicians would like to charge, or may be unable to pay anything at all. It is not surprising, therefore, that poor and rural communities face the most severe physician shortages. According to the Index of Medical Underservice, 20 million Americans live in communities where there is less than one physician per 2,000 people and at least 20 percent of the population is poor. [38]

The unavailability of providers is a particularly serious problem in maternity care. The state of Mississippi reported to the President's Commission on Ethical Problems in Medicine in 1983 that 51 of its 82 counties had no obstetricians. [39] This problem has grown worse in recent years in many parts of the country because of the exodus of obstetricians from materntiy practice in response to high liability insurance costs and the perceived risk of liability. A 1985 survey of obstetricains conducted by the American College of Obstetricians and Gynecologist found that 23.1 percent of all respondants indicated that they decreased their level of high risk obstetrical care as a result of the threat of malpractice. Nearly 14 percent indicated that they had decreased the number of deliveries they perform and 12.3 percent no longer practice obstetrics due to malpractice. [40]

Provider Acceptance of Medicaid: The problem of inaccessable maternity care for poor women strikes even those communities with an adequate supply of providers. For poor and uninsured pregnant women, care remains inaccessible unless the provider is willing to accept the patients' form of payment. Yet, large numbers of obstetricians will not accept Medicaid as payment and many more will not take patients who are uninsured. Indeed, among primary care physicians, obstetricians are the least likely to accept Medicaid patients. Nationally, nearly 36 percent of all obstetricians during 1977 and 1980 indicated that they provided care to no Medicaid patients, compared to 23 percent of pediatricians, 25 percent of general practioners and 20 percent of physicians in internal medicine. [41]

By all indications, this problem has become worse in recent

years. A West Virginia state Medical Association survey of its members in 1985 revealed that 40 percent of the obstetricians indicated that they no longer accepted Medicaid recipients as a result of the high cost of liability insurance. [42] As a result, the state's existing shortage of obstetricians was severely worsened for low income women. A survey conducted by the D.C. Medical Society had similar results. Of the obstetricians responding, 59 percent indicated that they would not accept Medicaid patients for obstetrical services.[43] Similar reports have come from New York, Rhode Island, Florida, Texas, Illinois and Massachusetts.

Program Application and Enrollment Barriers: The Medicaid program is the largest source of care to poor pregnant women, yet actual enrollment rates among eligible women are shockingly low. A study by the National Governor's Associaiton revealed that state enrollment among women who were newly eligible in the early 1980's ranged from 11 percent to 70 percent.[44] Several reasons account for low penetration, including the fact that because eligibility rules rapidly change, many women are unaware of their eligibility and fail to apply. Yet, many women would apply if eligibility rules were more clear. A survey of prenatal care patients in Indianapolis, Indiana revealed that of the uninsured women who appeared to be Medicaid eligible, 95 percent indicated that they would apply if they though they were eligible.[45]

However, even women who apply for Medicaid coverage may be effectively prevented from enrolling by administrative hurdles, such as complicated application forms, requirements of extensive documentation and long delays between application and notification of eligibility. In Mississippi, where Medicaid eligibility standards for pregnant women and children were made more generous in 1986, many of these problems prevenc enrollment, despite an agressive outreach campaign that was conducted to inform potentially eligible person about the expanded eligibility standards. Included in the campaign was a "hot line" to answer questions, guide people through the system and take complaints about the programs's implementation. An evaluation of the issues raised by callers during a three-month period in 1986 revealed serious difficulties in obtaining Medicaid coverage because of problems in the application process. Ten calls were from families whose eligibility had not been determined, although the mandatory 45 day eligibilty determination period had lapsed. In some cases, the families waited for a determination for as long as 6 months from the time that their application was filed. Three callers complained that they were not permitted to apply because Department of Public Welfare staff were not available to take their applicaitons at the intake center and another three callers were discouraged from applying because they were incorrectly told that they were not eligible.[46]

In the District of Columbia, Spanish-speaking applicants

face different enrollment problems. Although federal regulations clearly delineate the type of documentation that can be requested to accompany a Medicaid application to provide proof of residence and income, some applicants are required to produce documents that go beyond these guidelines. Literature distributed by the Medicaid agency, for example, instructs applicants to include such documentation as "recommendations from two persons that know [the applicant] well. [47] These additional requirements are potentially illegal as well as an unnecessary burden for applicants.[48] Other factors identified as discouraging completion of applications by Spanish-speaking families included a requirement that all applicants make an appointment at a location several miles away from the Hispanic community to submit the Medicaid application.

Such procedures not only can discourage women from obtaining Medicaid coverage, but can prevent them from obtaining needed care as well. At New York's Presbyterian Hospital it was routine procedure in the prenatal clinic until recently to deny prenatal care appointments to women who were unable to pay half of the projected costs of normal labor and delivery ($1600) even if the initial review indicated that they were likely to be Medicaid-eligible. Such patients were instructed to apply for Medicaid coverage and return to make an appointment only after the Medicaid card was in hand. [49] Similarly, among the families that called the Mississippi hot-line for assistance in obtaining Medicaid coverage, several callers indicated that they were refused services because they did not yet have a Medicaid card.[50]

Until recently, more subtle, but equally formidable barriers existed in Washington D.C. clinics. In order to be considered for free or income-adjusted care, patients who presented at the D.C. clinics for prenatal care were required first to apply for Medicaid. Like most communities, D.C.'s Medicaid applicaiton process often failed to inform applicants of their eligibility well beyond the 45 day period. Meanwhile, they received bills for all clinic services received, at full charge. The result was to discourage pregnant women from seeking care until their eligibility for Medicaid and/or income adjusted services was determined. To avoid large bills, women were forced to put off seeking care until well into their pregnancies.

Location of Services and Transportation: Even when insurance coverage is successfully obtained, low income women face other obstacles to care. The location of services is an important factor determining utilization. Two criteria used to evaluate the accessibility of services are the length of travel time to care and the type of transportation needed to get there. If the travel time is long, or the mode of transportation is unaffordable, inconvenient with children in two, or non-existant, health services may be available but are effectively inaccessible. [51]

Surveys of postpartum women confirm that long distances and high-cost transportation present major barriers to care. One study that surveyed 1,500 women in San Antonio found that the adequacy of transportation frequently influenced their use of prenatal care. [52] Inaccessibility due to the location of services is most severe among the poor who may be unable to afford the cost of transportation [53] and rural residents who may live in communities where no public transportation is available. [54] The American Nurses' Association recently learned about a southern county health department which offers prenatal care and which is centrally located to serve an entire region. The county, however, is without transportation. Women in adjoining counties traveling by bus can reach only as far as the county line, which is 15 miles from the clinic. [55]

When prenatal care services are not coordinated with public transportation, additional problems can result. Staff at a large Washington, D.C. public hospital report that one important reason why women fail to keep early morning appointments is that the bus system in the city's highest risk neighborhood do not even begin running at the hours patients are expected to be at the clinic.

V. Recommendations

The United States, the world's wealthiest nation enjoys the most sophisticated and extensive medical care. Yet, babies die in this country at rates higher than most other industrialized countries. In some communities and among some groups, infant death rates exceed those of Third World countries. The United States' exceptionally poor record can be traced to our failure to reduce the incidence of low birthweight, a condition that places infants at significant risk of death and lifelong disabling conditions. The real irony is that low birthweight is preventable by ensuring that pregnant women receive early and continuous prenatal care. However, virtually no progress has been made since 1980 in increasing the percentage of women who receive early prenatal care. At the current rate of progress, the nation will not meet the Surgeon General's 1990 goal that 90 percent of all women receive early care until the year 2005.

Prenatal care utilization can be increased only by eliminating the financial barriers to care that prohibit low income women from obtaining needed care. Several steps must be taken immediately to eliminate these barriers to care. These include:

- Nation-wide adoption of SOBRA: To date, 24 states and the District of Columbia have exercised the option to raise the income eligibility level for the Medicaid program above the AFDC payment level. (Table VI) If the remaining 26 states adopt SOBRA, a substantial

portion of uninsured women will be covered for maternity services.

- Swift Enactment by Congress of S. 422 and H.R. 1018, the Medicaid Infant Mortality Amendments of 1987: These companion bills enjoy bipartisan support and contain identical provisions to permit states to raise the income eligibility levels for pregnant women and infants up to 185 percent of the federal poverty level. This legislation should help provide coverage for the sizable portion of uninsured pregnant women who work and thus have income disqualifying them from the Medicaid program. It should be included in the Budget Reconciliation package.

- Additional funding for residual programs to ensure the availability of providers in medically underserved areas: Key programs like the community and migrant health centers and the Maternal and Child Health Block Grant provide high quality primary health care but cannot serve all who are in need because of limited funds. 2.5 percent oa all births nationwide and over 5 percent of births to low income women in the U.S. occur at health centers. Recently passed S. 1441 and its pending companion bill H.R. 1326 provide $35 million in funds to community and migrant health centers to strengthen and expand services for pregnant women and infants.

- Enforcement of Anti-dumping provisions: The Consolidated Omnibus Reconciliation Act of 1986 [P.L. 99-272] sets forth for prohibits Medicare-participating hospitals from denying access to patients in emergency situations. Under these provisions, all hospitals that accept Medicare reimbursement may not deny treatment to uninsured patients in emergency circumstances unless: 1) the patient can be "appropriately" transfered to another hospital. For a high risk woman in labor, the situations in which a transfer is "appropriate" are very limited; 2) the patient, if a pregnant women, is not in "active labor". Hospitals that fail to comply with these provisions can have their Medicare agreements suspended or terminated. Moreover, a hospital that knowingly violates these provisions, as well as the responsible emergency room physician, are both subject to civil money penalties of up to $25,000 for each violation. Finally, persons harmed by inappropriate transfers, as well as the receiving facilities to which an emergency patient is inappropriately transferred and that suffer a financial loss, may file a private suit under the new law against the offending hospital and physicians.

These new "anti-dumping" provisions have not been routinely enforced, unfortunately, and must be in order to protect against inappropriate transfers. Moreover the provisions should also be expanded to apply to hospitals that are regional referral centers and that refuse to accept hospital-to-hospital emergency transfers (as opposed to those patients that simply show up at their emergency room door). The inability to gain access to regional specialty center services is a particularly severe problem for high risk pregnant women and newborns. For example in December, 1986 the MacAllen Medical Center in MacAllen Texas, is known to have refused admission to four newborn infants requiring emergency neonatal services. One of the infants died as a result of the delayed hospital admission.

- o Prohibition against preadmission deposits: Pregnant women must preregister for delivery services to ensure that they receive timely, risk-appropriate care. Yet many uninsured, low income women cannot get such care because they cannot meet hospitals' requirement of a preadmission deposit. Pregnant women must be permitted to register for delivery regardless of their insurance status and all Medicare and Medicaid funded facilities should be prohibited from imposing such requirements as a condition of certification.

These are short terms remedies to a problem that requires long-term solutions to improve the health of America's children. A comprehensive health policy that considers accessability, availability and quality of care is needed. In the meantime, however, these simple measures will go far toward preventing unnecessary infant death and disability.

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TABLE I

INFANT MORTALITY & LOW BIRTHWEIGHT
1965 - 1985

	Infant Mortality Rate*	Percent Babies Born at Low Birthweight
1965	24.7	8.3
1966	23.7	8.3
1967	22.4	8.2
1968	21.8	8.2
1969	20.9	8.1
1970	20.0	7.9
1971	19.1	7.7
1972	18.5	7.7
1973	17.7	7.6
1974	16.7	7.4
1975	16.1	7.4
1976	15.2	7.3
1977	14.1	7.1
1978	13.8	7.1
1979	13.1	6.9
1980	12.6	6.8
1981	11.9	6.8
1982	11.5	6.8
1983	11.2	6.8
1984	10.6	6.7
1985	10.8	6.8

* Deaths per 1,000 live births

Source: National Center for Health Statistics

Table II

Infant Mortality Rates
1950-1985
Selected Countries

Country	1950-1955		1955-1960		1960-1965		1965-1970		1970-1975		1975-1980		1980-1985		% Change 1950-55 to 1980-85
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	
Australia	24	(4)	21	(5)	20	(6)	18	(9)	17	(14)	12	(10)	10	(12)	-58
Belgium	45	(14)	35	(14)	27	(14)	23	(16)	19	(18)	13	(12)	11	(17)	-76
Canada	36	(11)	30	(11)	26	(13)	21	(11)	16	(9)	12	(10)	9	(9)	-75
Denmark	28	(8)	23	(6)	20	(6)	16	(6)	12	(2)	9	(2)	8	(5)	-71
Finland	34	(10)	25	(9)	19	(5)	15	(5)	12	(2)	9	(2)	6	(1)	-82
France	45	(14)	33	(12)	25	(11)	21	(11)	16	(9)	11	(9)	9	(9)	-80
German Dem. Rep.	58	(18)	44	(18)	31	(18)	21	(11)	17	(12)	13	(12)	11	(17)	-81
Germany, Fed. Rep.	48	(16)	37	(15)	28	(16)	23	(11)	22	(20)	15	(8)	11	(17)	-77
Hong Kong	79	(20)	54	(20)	33	(19)	23	(16)	17	(12)	13	(12)	10	(12)	-87
Iceland	21	(2)	17	(1)	[illegible]	(3)	13	(1)	12	(2)	9	(2)	6	(1)	-71
Ireland	41	(12)	34	(13)	28	(15)	23	(16)	18	(16)	15	(18)	10	(12)	-76
Japan	51	(17)	37	(15)	24	(10)	16	(6)	12	(2)	9	(2)	6	(1)	-88
Luxembourg	43	(13)	37	(15)	29	(17)	21	(11)	16	(9)	13	(12)	9	(9)	-79
Netherlands	24	(4)	19	(3)	16	(2)	14	(3)	12	(2)	10	(7)	8	(5)	-67
Norway	23	(3)	20	(4)	17	(3)	14	(3)	12	(2)	9	(2)	8	(5)	-65
Spain	62	(19)	51	(19)	[illegible]	(20)	33	(20)	21	(19)	16	(20)	10	(12)	-84
Sweden	20	(1)	17	(1)	15	(1)	13	(1)	10	(1)	8	(1)	7	(4)	-65
Switzerland	29	(9)	23	(6)	[illegible]	(6)	17	(8)	13	(8)	10	(7)	8	(5)	-72
United Kingdom	28	(6)	24	(8)	22	(9)	19	(10)	17	(14)	14	(16)	10	(12)	-64
United States	28	(6)	26	(10)	25	(11)	22	(16)	18	(16)	14	[illegible]			-61

(Rates are rounded to the nearest whole number)
Source: United Nation's Children's Fund

TABLE III

Percentage of Babies Born to Women
Receiving First Trimester Care, By Race

Year	All Races	White	Black
1969	68.0	72.4	42.7
1970	67.9	72.4	44.3
1971	68.6	73.0	46.6
1972	69.4	73.6	49.0
1973	70.8	74.9	51.4
1974	72.1	75.9	53.9
1975	72.3	75.9	55.8
1976	73.5	76.8	57.7
1977	74.1	77.3	59.0
1978	74.9	78.2	60.2
1979	75.9	79.1	61.6
1980	76.3	79.3	62.7
1981	76.3	79.4	62.4
1982	76.1	79.3	61.5
1983	76.2	79.4	61.5
1984	76.5	79.6	62.2
1985	76.3	79.8	61.2

TABLE IV

Percentage of Babies Born to Women
Receiving Late or No Prenatal Care, By Race

Year	All Races	White	Black
1969	8.1	6.3	18.2
1970	7.9	6.2	16.6
1971	7.2	5.8	14.6
1972	7.0	5.5	13.2
1973	6.7	5.4	12.4
1974	6.2	5.0	11.4
1975	6.0	5.0	10.5
1976	5.7	4.8	9.9
1977	5.6	4.7	9.6
1978	5.4	4.5	9.3
1979	5.1	4.3	8.9
1980	5.1	4.3	8.8
1981	5.2	4.3	9.1
1982	5.5	4.5	9.6
1983	5.6	4.6	9.7
1984	5.6	4.7	9.6
1985	5.6	4.7	10.3

TABLE V

PERCENTAGE OF WOMEN
AGED 15-44, BY SELECTED CHARACTERISTICS,
ACCORDING TO TYPE OF MEDICAL COVERAGE,
1984

Characteristic	Group	Individual	Medicaid	Other	None
All	67	10	9	3	17
INCOME					
< $5000	10	10	42	3	39
$5000 - $9999	29	11	30	3	33
$10,000 - $14,999	58	11	8	5	24
$15,000 - $24,999	74	12	3	4	14
$25,000 - $34,999	84	9	1	3	9
$35,000 or over	86	9	*	4	8
POVERTY					
< 100%	17	10	40	2	36
101-149%	48	13	10	6	30
150-249%	71	12	3	4	16
250% or over	85	9	1	3	8

Source: Gold and Kenney

Children's Defense Fund

122 C Street, N.W.
Washington, D.C. 20001

Telephone (202) 628-8787

Table VI

September, 1987

MEDICAID COVERAGE OF CHILDREN UNDER 18 AND PREGNANT WOMEN - SEPTEMBER, 1987

STATE	ALL CHILDREN UNDER 18 WITH FAMILY INCOMES BELOW STATE POVERTY LEVELS	MEDICALLY NEEDY WOMEN & CHILDREN	PREGNANT WOMEN & CHILDREN UNDER AGE ONE WITH FAMILY INCOMES BELOW THE FEDERAL POVERTY LEVEL
ALABAMA	no	no	N
ALASKA	yes	no	N
ARIZONA	yes	yes	Y
ARKANSAS	yes	yes	Y,P
CALIFORNIA	yes	yes	N
COLORADO	no	no	N
CONNECTICUT	yes	yes	Y,*
DELAWARE	yes	no	Y,*
DISTRICT OF COLUMBIA	yes	yes	Y,*
FLORIDA	yes	yes	Y,*
GEORGIA	yes	yes	N
HAWAII	no	yes	N
IDAHO	no	no	N
ILLINOIS	yes	yes	Y
INDIANA	no	no	N
IOWA	yes	yes	N
KANSAS	yes	yes	N
KENTUCKY	no	yes	N
LOUISIANA	no	yes	L
MAINE	yes	yes	N
MARYLAND	yes	yes	Y,*,P
MASSACHUSETTS	yes	yes	Y,*,P
MICHIGAN	yes	yes	Y,*
MINNESOTA	yes	yes	Y,*
MISSISSIPPI	yes	no	Y
MISSOURI	yes	no	Y
MONTANA	yes	yes	N
NEBRASKA	yes	yes	N
NEVADA	no	no	N
NEW HAMPSHIRE	no	yes	N
NEW JERSEY	yes	yes	Y,*
NEW MEXICO	no	no	Y
NEW YORK	yes	yes	N
NORTH CAROLINA	yes	yes	Y,*,P
NORTH DAKOTA	no	no	N
OHIO	yes	no	Y
OKLAHOMA	yes	yes	Y
OREGON	yes	yes	Y
PENNSYLVANIA	yes	yes	N
RHODE ISLAND	yes	yes	Y,*,P
SOUTH CAROLINA	yes	no	Y,*
SOUTH DAKOTA	no	no	N
TENNESSEE	yes	yes	Y
TEXAS	yes	yes	Y,*
UTAH	yes	yes	N
VERMONT	yes	yes	Y
VIRGINIA	no	yes	N
WASHINGTON	no	yes	Y
WEST VIRGINIA	no	yes	Y
WISCONSIN	no	yes	N
WYOMING	no	no	N

Y: Final action has been taken to implement SOBRA
L: Final action is still pending, but implementation is likely
N: No action expected this year
P: State plans to implement presumptive eligibility portion of SOBRA
?: Final decision is still unclear
*: State has waived application of an asset test

Mr. WEISS. Thank you very much, Ms. Hughes.

We will operate, as I said, under the 5-minute rule, which means simply that each of us will only ask questions and get responses for 5 minutes before yielding to someone else, and that way each of us will have a chance to ask questions.

Ms. Ferrell, let me review some of your testimony. You said that you were unable to get on Medicaid until a few weeks before your baby was born. Is that correct? Pull the microphone close to you, OK?

Ms. FERRELL. Yes, that's correct.

Mr. WEISS. And if it wasn't for the help of your doctor, Dr. Niles, you probably would not have gotten on Medicaid at all because they said you weren't eligible. Is that right?

Ms. FERRELL. That's correct.

Mr. WEISS. May I ask how much you were earning at that time?

Ms. FERRELL. About $8,100 a year.

Mr. WEISS. Again, you'll have to speak up louder.

Ms. FERRELL. About $8,000 a year.

Mr. WEISS. About $8,000.

Ms. FERRELL. Yes.

Mr. WEISS. And whom were you supporting at that time?

Ms. FERRELL. Myself and my older son, my 5-year-old.

Mr. WEISS. You have a 5-year-old?

Ms. FERRELL. Yes.

Mr. WEISS. And the Medicaid people told you that that put you $1,400 over the limit for Medicaid. Is that right?

Ms. FERRELL. Yes.

Mr. WEISS. Now, Dr. Niles, however, continued to provide prenatal care to you in spite of that—is that right—even though you——

Ms. FERRELL. Yes, he did.

Mr. WEISS [continuing]. You were not at that time able to pay for that care. Is that correct?

Ms. FERRELL. Sometimes I was and sometimes I was not.

Mr. WEISS. But he continued——

Ms. FERRELL. Yes.

Mr. WEISS [continuing]. Providing care for you.

And subsequently, Medicaid paid the rest retroactively. Is that correct?

Ms. FERRELL. Yes, they did.

Mr. WEISS. How old is your baby now?

Ms. FERRELL. He is 2 months old.

Mr. WEISS. And how is he?

Ms. FERRELL. He's fine.

Mr. WEISS. Ms. Longacker, in your situation you said you were unable to get any prenatal care at all. Is that correct?

Ms. LONGACKER. Yes, sir.

Mr. WEISS. And there were no clinics that offered free care for uninsured pregnant women that were closer than Albany. Is that right?

Ms. LONGACKER. That's true.

Mr. WEISS. And how far was that from where you were?

Ms. LONGACKER. Thirty-five miles.

Mr. WEISS. Tell me how you felt about not being able to afford prenatal care?

Ms. LONGACKER. Pretty lousy.

Mr. WEISS. Did it worry you——

Ms. LONGACKER. It wasn't fair. Yes, it worried me greatly. I prayed the whole 9 months.

Mr. WEISS. How were you able to afford the hospital fees for delivering the baby?

Ms. LONGACKER. I didn't. I took it for granted. I walked in. I was in labor. They delivered the baby. Needless to say, I didn't pay the bill. I got sued.

Mr. WEISS. The hospital sued you subsequently?

Ms. LONGACKER. Of course.

Mr. WEISS. Now, is there anything else that you would like to tell us that you think would help other women in the kind of situation that you found yourself in?

Ms. LONGACKER. It shouldn't happen. It's just not right. We're talking, you know, a new generation. It's just not fair.

Mr. WEISS. And could you tell us the condition of the child that was born?

Ms. LONGACKER. Mine?

Mr. WEISS. Yes.

Ms. LONGACKER. Right now? As he is now?

Mr. WEISS. Yes.

Ms. LONGACKER. He is healthy basically, but he does have learning disabilities. He is hearing impaired. I do not know if that is the cause of having no prenatal care, but I guess I'll never know.

Mr. WEISS. Thank you very much.

Ms. LONGACKER. Thank you.

Mr. WEISS. Ms. Bass, what unique contribution can the Federal Government make to solve the problems of infant mortality and birth defects that private, nonprofit organizations, such as the National Council of Negro Women or the March of Dimes, can't?

Ms. BASS. Assure the appropriate legislation that will expand the Medicaid eligibility so that there are not women that are cut out of services because they make a few hundred dollars too much in someone's opinion.

Assure that there are federally funded community health centers in communities around the country because many poor and low-income women do use these type of services.

Allow and assure that more appropriate health care personnel who can relate better to these women can be certified and used, because patient-provider relations are very important in whether people will continue to receive prenatal care even if they do get there one time.

Mr. WEISS. In your judgment, why has there been no progress in closing the gap between black and white infant mortality and prenatal care?

Ms. BASS. Well, I think it relates to the persistent problems of economic and financial disparities which plague continually this society and which put the poor, blacks, and other minorities at risk not only for greater infant mortality, but for all health problems.

Mr. WEISS. Thank you.

Mr. Lightfoot.

Mr. LIGHTFOOT. Thank you, Mr. Chairman.

I would like to join you in welcoming our new member to the panel. I see she had to leave as I look over there.

Mr. WEISS. She'll be back.

Mr. LIGHTFOOT. OK. Well, we will send her a note. Our offices are located on the same floor.

Ms. Bass, I would like to follow up on the chairman's question. Do you see the coordination of Federal, State, and local resources targeted toward prenatal care and reducing infant mortality as being effective, or do we need to improve this? Do you have any recommendations for us in that area?

Ms. BASS. We would certainly recommend increased coordination between Federal, State, and local services and resources to improve the care. There are many women who still fall through the cracks of Federal, State, and local services. There are many people in general who fall through the cracks by one way or another, so there is a great need for more coordination.

Mr. LIGHTFOOT. Do you perceive that as a problem of, shall we say, the design of the system, or is it the egos of the various agencies that, you know, everyone wants to do their own thing so that we are not getting the type of cooperation that we should?

Ms. BASS. I think there is some—well, I think primarily it is a matter of the design of systems that needs to be improved. We need a better analysis of the community needs so that the systems can be designed and tailored to better reach those women who most need the services.

I think that there has always been a tendency for poor women to—poor people in general—to receive less than the best care, and responses from health care providers and systems. Sometimes it is likened to blaming the victim.

Mr. LIGHTFOOT. Ms. Ferrell, if I understand your statements you made in your opening comments, you were justifiably very frustrated about the process you had to go through with all the paperwork and being a number.

Is your basic frustration with the system, or does it go deeper into the benefits that are there, or not there in your case?

Ms. FERRELL. The main thing that bothered me was that the person does this work all the time. They know right from the beginning whether or not I am eligible for the Medicaid. They call you and they send you back and forth to pick up all these papers and whatnot. I figure once he knew my income—and he knew my income the first day I was there—he would know whether or not I was eligible. Whether it was his place to tell me or not, there should have been someone there to tell me.

He acted as though he was doing me a favor. And to me, I felt like I was doing him a favor because as long as there are pregnant women that need Medicaid, he has a job. No pregnant women, then he has to find another job somewhere.

Mr. LIGHTFOOT. Well, I won't say that, but I think you're probably right.

Ms. Longacker, since we only have 5 minutes I want to run right on down the panel. The comment you made that struck me was that your husband is back in a subcontracting position. And it seems apparent that you want to be self-sufficient and able to take care of yourself as you were before the company was sold.

Do you feel that at the time you received some assistance, the incentive was to keep you on that assistance rather than give you some incentive like now, for example, where maybe a little bit of a supplement would really make the difference, but you can't qualify because you are earning too much money? Is that a correct assessment?

Ms. LONGACKER. That's a loaded question. I'll tell you. Yes, it was to keep me there. We fought to get off.

Mr. LIGHTFOOT. The reason I asked——

Ms. LONGACKER. And all I needed was a little bit of help, you know, like you say, a little supplement. I could have a little bit of medical. I could be self-sufficient. It was to keep me there, though.

Mr. LIGHTFOOT. The reason I asked the question is because there is a lot of talk about welfare reform right now, and Congress is looking at these things. And I happen to agree with your point of view that the incentive should be to allow people to get off assistance who want to get off. And unfortunately, I think the way a lot of the formulas are constructed, the incentive is to stay on it, which a lot of people don't want to do. But, they really don't have any choice because they are not earning enough money, but yet they lose that little bit of assistance that they need. You've been through it, so you are——

Ms. LONGACKER. Yes. We were afraid to get off because I knew I was going to lose the medical. I called. I asked what possibly the guideline would be. How much could I make just to keep the Medicaid because of the three children? And I was told, you know—it was a ridiculously low amount. There was just no way. So, it was either get off or stay on. I got off.

Mr. LIGHTFOOT. And I had a question for Ms. Hughes, but I've got the red light. I will wait for my next turn.

Mr. WEISS. Ms. Hughes, the Children's Defense Fund study of Washington, DC, found terrible delays in clinics for poor pregnant women. Is that right?

Ms. HUGHES. Yes.

Mr. WEISS. And do you think that these delays are typical of other cities, or is it just peculiar to Washington?

Ms. HUGHES. What we found is not unusual.

Mr. WEISS. Would you speak into the larger microphone?

Ms. HUGHES. Yes.

We found in the District of Columbia many problems of access to care, many of which are either in the process of being addressed or have recently been addressed. However, these are not unusual to the District of Columbia. Such problems exist around the country. And we hear stories about them weekly. Others have documented them as well.

Mr. WEISS. You stated that the financial barriers to prenatal care are the most important. What are the other major barriers to care?

Ms. HUGHES. Well, as I indicated earlier, there is a series of them, including lack of transportation to care, lack of child care, clinic hours that make it impossible for a woman who is working to seek services unless she takes off from work and then forgoes income during that period, providers that will not accept Medicaid

recipients and uninsured women, as well as lack of providers in communities, as I described in upstate New York.

Mr. WEISS. And, in your opinion, why has there been no progress in reducing infant mortality and increasing access to prenatal care since 1980?

Ms. HUGHES. Well, there are a variety of factors. The first is that there has been a dramatic increase in the number of Americans who have no health insurance, and that in turn is a function of a variety of things that I am happy to go into detail about, but are already described in my testimony.

Second, there has been a dramatic increase in the proportion of Americans who are in poverty. This is important because people who are in poverty are more likely to be uninsured and more likely not to have access to health services.

Finally, there has been a series of reductions in funding for key maternal and child health programs, most of which occurred between 1981 and 1982. We are just now returning to funding levels that resemble pre-1981 levels. The modest increases are important and good, but we need to go much further because programs currently cannot meet the existing need. Moreover, as we have returned the funding levels to pre-1981 levels, the pool of women that need the care has greatly increased due to rising uninsuredness and poverty. So, we are only now beginning to make steps in the right direction, and we have considerably farther to go.

Mr. WEISS. There are a number of studies that indicate that prenatal care can save the Federal Government money. How do you feel about that?

Ms. HUGHES. That is absolutely true. There is ample evidence to demonstrate that prenatal care is an important investment because it prevents poor health and unnecessary death. The Institute of Medicine in its report of 1985 found that for every $1 spent on prenatal care, another $3.38 can be saved in the first year alone. There are other studies that demonstrate that that same dollar can save over $11 over the lifetime of a child by preventing the need for special education and additional health services. And clearly, these are savings not only to individual families, but to society and to the Federal Government.

Mr. WEISS. I understand that many clinics bill patients and only later forgive those bills. And in a report that I think you wrote last year, you said that 23 State agencies said that one or more hospitals in the State imposed preadmission cash deposits for women who wanted prenatal care. You indicate that in your testimony.

What is the impact of such practices as that?

Ms. HUGHES. It prevents women from registering before they go into labor. It prevents them from having their records at the hospital at the time of labor and delivery. And ultimately that means that the hospital is ill-prepared to deal with the woman's circumstances. She may be diabetic. She may have other problems. Without her records and advanced notice of her labor, the hospital cannot prepare for her condition and, therefore, simply may be unable to meet her needs, placing both the mother and the baby at high risk.

The other important consideration is that unless a woman is allowed to preregister, she may not be delivered in the risk-appropri-

ate facility. Some women must be delivered in facilities that are equipped to deal with a very, very sick infant or a very sick mother. If she is not permitted to preregister, she goes to whatever hospital will let her in, without the assurances that the services and the equipment will be available to meet her needs.

Mr. WEISS. Thank you.

Before I yield, let me just indicate that before she left, Ms. Pelosi indicated in a note that she had another committee assignment that she had to attend, but that she didn't think it would last very long, and she will be returning.

Mr. Lightfoot.

Mr. LIGHTFOOT. Thank you, Mr. Chairman.

Ms. Hughes, since you are warmed up, we will just stay with you for a minute or two.

Earlier this summer, this subcommittee held a hearing on patient dumping, and of particular interest to us at that time was the implementation of the antidumping provisions. I believe you mentioned them in your opening testimony.

To your knowledge, have these provisions had any effect in making sure that pregnant women are not denied emergency hospital care?

Ms. HUGHES. In those circumstances where both the hospital and/or the patient know about it, it can work. Unfortunately, that is not happening enough. Many hospitals, it turns out, are unaware of the new law, and many patients are unaware of it as well. We hear of situations where women are denied access to delivery services even when they are in active labor.

Mr. LIGHTFOOT. I think this was one of the problems identified in the hearing that the information was not being disseminated to enough people who understood that the emergency room did have to give treatment to a pregnant woman. Do you have any suggestions on what we could do to more or less get the word out, so to speak?

Ms. HUGHES. Well, HCFA certainly has a role to play in informing hospitals that receive Medicare reimbursements about the new law, since the law is tied to the Medicare program. I think that that would be an important first step.

Mr. LIGHTFOOT. There have been some recent changes with Medicaid. How do you feel about them? Do you believe these changes will reduce any of the financial barriers that have existed to prenatal care? Or what is your opinion on that?

Ms. HUGHES. The Medicaid expansions that seek to make eligible larger numbers of pregnant women and infants are essential. It has been well demonstrated here I think that pregnant women face enormous barriers to receiving care. Medicaid enrollment can facilitate access to services.

Mr. LIGHTFOOT. I represent a rural area, as you are probably aware. One of the problems I have with Federal programs in general, whether it is prenatal care or the highway fund, is that the formulas we use at the Federal level basically identify numbers where large groups of people are located, but they don't necessarily identify problems. We have problems in rural areas with poor women, just as you find in big metropolitan areas.

I might also say I think the bureaucracy tends to be a little better in these rural areas because they are not giv- a number like you were; they are treated as an individual. And maybe that is because of the large masses of people that you find.

I guess this is a parochial question. Now looking at the rural areas, the eligibility definitions—and I think Ms. Longacker was a victim of that too—attempt to make something work everywhere across the U.S.A., whereas everybody across the U.S.A. are in entirely different situations. Do you see this as a problem? And if you do, do you have any recommendations on what we might do to improve the definitions because Ms. Ferrell in Washington, DC, is in an entirely different set of circumstances than a woman would be in my hometown; $8,000 out there will go a whole lot further than it will here because I live both places and know. You know, a bar of soap that's a buck and a quarter here I can get for 67 cents at home. And it makes a lot of difference where the money goes.

Ms. HUGHES. Programs should always be designed to meet the specific needs of a population, and that is where community involvement and State and local involvement is essential in designing programs and setting forth specifications for programs. And I couldn't agree with you more.

Mr. LIGHTFOOT. Well, then that goes back to what Ms. Bass and I were discussing, the cooperation between all of the agencies, Federal, State, and local. Do you perceive that there is discord among the agencies that could be worked out?

Ms. HUGHES. There is certainly lots of room for improvement. The lack of coordination and the fragmentation that exits in a community and amongst Federal agencies is enormous. And there are ways of working that out. There are many examples of how communities have successfully organized services by getting agencies to talk to each other and to bring in community members to work together to define the programs and to design the programs. It is not an impossibility. And it is an enormous problem.

Mr. LIGHTFOOT. Well, I appreciate all four of you coming this morning to discuss this issue. I think we have some new ideas, and I would like to ask the chairman, if possible—we normally leave the record open for a few days after we close the hearing—that if any of you have any recommendations and ideas you think we could use to help improve the situation, you be allowed to submit that at a later date.

Mr. WEISS. That is perfectly appropriate. Without objection, th , will be done.

[Recommendations submitted by Ms. Longacker and Ms. Hughes are in app. 1, p. 199.]

Mr. WEISS. Ms. Ferrell, let me again underscore the testimony that you gave. It ultimately turned out that you were, in fact, eligible for Medicaid. Is that correct?

Ms. FERRELL. I don't know to this day whether it turned out that I was eligible for Medicaid or not. All I know is that Dr. Niles talked to the right people, and I had the Medicaid in time for delivery.

Mr. WEISS. You received Medicaid reimbursement. Is that right?

Ms. FERRELL. I received Medicaid. Yes.

Mr. WEISS. Right.

But if it had been left just to you, without the benefit and assistance of your doctor, as far as you were told, you were not qualified. You were not going to receive Medicaid assistance.

Ms. FERRELL. I would not qualify for it at all.

Mr. WEISS. How did you happen to find your doctor? How did you get to him?

Ms. FERRELL. How did I find the doctor originally?

Mr. WEISS. Dr. Niles. How did you get to him to begin with?

Ms. FERRELL. I don't understand.

Mr. WEISS. How did you learn that Dr. Niles would be your doctor even though you weren't assured of being able to pay him at that point?

Ms. FERRELL. Well, he felt that all women should have prenatal care. And he said that we would be able to work something out.

Mr. WEISS. Where did you hear about him? How did you hear about him?

Ms. FERRELL. Through a service, where you dial the number "DOCTORS."

Mr. WEISS. Say it again.

Ms. FERRELL. The number that is on the TV—"DOCTORS." You dial "DOCTORS" and they give you a list of various doctors in your area and the description of the doctor and his personality and the people that he works with. That's how I found him.

Mr. WEISS. So, you saw an announcement on television?

Ms. FERRELL. Yes.

Mr. WEISS. Is that right?

Ms. FERRELL. Right.

Mr. WEISS. And you made the call, and you were lucky enough to get a doctor who then was able to help you. Is that right?

Ms. FERRELL. Yes, that's right.

Mr. WEISS. OK, thank you.

Ms. Longacker, did you attempt to get the assistance of anybody else, any agency or private voluntary organization to provide any help to you when you found out that you didn't have any coverage at all, or were you left more or less to your own devices at that point?

Ms. LONGACKER. No, I didn't. I was so discouraged, I just gave up.

Mr. WEISS. Ms. Hughes, in a report that you wrote earlier this year, you stated that malpractice insurance premiums have discouraged many ob-gyns from providing care to poor women. Would you expand on that just a bit?

Ms. HUGHES. There are numerous studies that survey obstetricians and their participation in the Medicaid program, and many have indicated that they will not serve Medicaid-eligible women for reasons related to the malpractice insurance premium costs.

Unfortunately—that low participation in these cases is usually based on an assumption on the part of many obstetricians that Medicaid-eligible women are more litigious and therefore will contribute to higher premium costs for themselves and put them at risk of being sued. It is true that low-income women are generally at higher risk, and therefore potentially at higher risk of poor pregnancy outcomes. However, there is no evidence to suggest that low-income women actually sue more than non-low-income women. And in fact, all evidence points to exactly the opposite conclusion.

For example, poor women traditionally receive services that often can be described as substandard and they therefore may not have a sense of what a positive medical experience might be, and therefore have no grounds from which to evaluate when they have been treated poorly.

Second, low-income women are likely to have a very difficult time finding a lawyer who can represent them. This relates, in part, to the rules governing legal services attorneys. Legal services attorneys are not permitted to accept malpractice cases unless it is demonstrated that the individual was unable to get pro bono work from someone else.

Finally, the evidence against the notion that low-income women sue more is based on common sense, which says that many claims or awards are based on potential earnings of the claimant. And low-income families clearly have limited earnings or potential earnings and, therefore, the awards are not as great as for other individuals.

All of those factors discourage attorneys from representing Medicaid-eligible women. And all of these things I have just enumerated are counter to assumptions that low-income women actually sue more.

Mr. WEISS. Thank you all very, very much. It was excellent testimony, and provided a great deal of help to this committee in its deliberations. We appreciate your taking time from your schedules and traveling the distance that you did, Ms. Longacker, to be with us. Thank you very, very much.

Ms. LONGACKER. Thank you.

Mr. WEISS. Our next panel of witnesses includes Richard Fogel, Assistant Comptroller General of the General Accounting Office, and he will be accompanied by James Linz, group director of the Human Resources Division of GAO, and Martin Landry, evaluator in charge from the GAO Atlanta regional office.

Before you take your seats, if you will raise your right hand?

Do you affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

Let the record indicate that each of the witnesses responded in the affirmative.

Let me thank you for the excellent report which is being released today and for joining us today.

Mr. Fogel, we will begin with you when you are ready.

STATEMENT OF RICHARD FOGEL, ASSISTANT COMPTROLLER GENERAL, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JAMES LINZ, GROUP DIRECTOR, HUMAN RESOURCES DIVISION, AND MARTIN LANDRY, EVALUATOR IN CHARGE, ATLANTA REGIONAL OFFICE

Mr. FOGEL. Thank you, Mr. Chairman.

I would like to introduce my colleagues. Jim Linz is on my right, and Martin Landry is putting up some charts to help visually portray what we are reporting to you today.

We are very pleased to be here to discuss the results of our report issued to the subcommittee on problems encountered by Medicaid recipients and uninsured women in obtaining prenatal

care. Our report is based on the results of interviews with 1,157 Medicaid recipients and uninsured women and analyses of appropriate medical records to determine the number and timing of their prenatal care visits and the barriers they perceived as preventing them from obtaining care earlier or more often.

We did our interviews and analyses in 32 communities in 8 States. There is no doubt that the costs of inadequate prenatal care are high in terms of both infant mortality and increased health care cost. As you noted, more than $2.5 billion is spent annually on neonatal intensive care services primarily to low birthweight babies. According to the Institute of Medicine, for every dollar spent on prenatal care for high-risk women, such as those we interviewed, over $3 could be saved in the cost of care for low birthweight babies.

In 1980 the Surgeon General set out specific objectives for improving infant health care and reducing infant mortality by 1990. From the results of our work, it appears unlikely that the Surgeon General's goal will be met by 1990, particularly for the approximately 26 percent of women of child-bearing age who lack private health insurance.

Of the women we interviewed—and this is shown in the first chart that we have up—about 63 percent obtained prenatal care we considered insufficient because they did not begin care within the first 3 months of their pregnancy or made eight or fewer visits for care. About 12.4 percent of the babies born to these women were low birthweight babies. The national average is only 6.8 percent. And while neither is good, we believe this gives pretty good evidence that by not receiving adequate care, these women present more of a problem for their children.

Insufficient prenatal care was a problem for all women of all child-bearing ages, of all races and from all sizes of communities. But those most likely to obtain insufficient care were women who were uninsured, poorly educated, black or Hispanic, teenagers, or from the largest urban areas. The percentage of Medicaid recipients and uninsured women who had insufficient prenatal care ranged from 14 percent in Kingston, NY, to 82 percent in Montgomery, AL.

In all but two communities studied—again, Kingston, NY, and Troy, AL—a higher percentage of privately insured women obtained adequate care. Now, this is what this chart shows. Overall, 81 percent of privately insured women studied in our 32 communities obtained adequate care compared with 36 percent of the women on Medicaid and 32 percent of the women with no health insurance. So, there was a very big disparity.

We asked the Medicaid recipients and the uninsured women interviewed what kept them from obtaining prenatal care earlier or more often. Barriers to early or more frequent care varied according to such factors as age, race, and size of community with about half of the women interviewed citing multiple barriers. But three barriers predominated in virtually every demographic group of women: lack of money to pay for care, lack of transportation to the provider of care, or lack of awareness of the pregnancy.

The importance of these three and other barriers differed, however, by community. For example, none of the women interviewed

in Birmingham, AL, cited lack of money as the most important barrier—that is because Birmingham provides free prenatal care—whereas 27 percent of the women interviewed in Los Angeles cited money as the primary problem. In Los Angeles the system charges $20 per visit for the first seven prenatal care visits.

Transportation was more frequently named as a barrier in rural and midsize cities that lack public transportation systems.

Over 25 percent of women in 5 midsize communities said that lack of awareness of the pregnancy was the most important barrier to prenatal care, while less than 10 percent of women in 5 other similar size communities cited this barrier.

Because of such differences, programs to overcome barriers to prenatal care need to be tailored to meet the needs of individual communities. In that regard, we strongly support what some of the members of the previous panel said. Each community must look at its situation to determine what specific barriers it has that must be overcome.

Federal funds are available to assist States and communities in such efforts. Specifically, States can extend Medicaid eligibility to pregnant women with incomes up to the Federal poverty level. And as of today, about half of the States have done so. We found that Medicaid coverage reduced from 23 to 10 percent the significance of lack of money as a barrier to prenatal care for women we interviewed. CBO has estimated that the Federal Medicaid cost would have increased about $190 million in fiscal year 1987 had all States expanded eligibility.

States can extend Medicaid coverage to pregnant women while their Medicaid applications are being processed. Of the Medicaid recipients who lacked money as a barrier to care, most said they encountered problems in establishing eligibility. And this could delay women receiving prenatal care services under Medicaid. CBO estimated that presumptive eligibility, as it is called in the jargon, would only cost the Federal Government about $6 million over a 3-year period. But as of June 1987, no States had implemented presumptive eligibility primarily because of administrative problems. And we have recommended that the Secretary of HHS through HCFA start working with the States to try to resolve those types of problems.

States and communities could allocate additional Maternal and Child Health Care block grant funds to prenatal care services. Such funds could be used, among other things, to fund educational and outreach services to get women into prenatal care earlier and to provide transportation services to help them get to a health care provider.

Another solution suggested by some is to increase Medicaid reimbursement rates for maternity services to encourage more private practice physicians to accept Medicaid patients. Few of the women we interviewed, however, had problems finding a health care provider to see them. Specifically, about 61 percent obtained care at a hospital or public health clinic. Only 2 percent of the women who obtained insufficient care cited difficulty in finding a doctor as the most important barrier to earlier, more frequent care.

In addition, the participation rate of ob-gyns in Medicaid is low, ranging from about 6 percent in the South to about 11 percent in the West as of 1984.

[Subsequent to the testimony, GAO learned that the study it cited noting participation rates of ob/gyns in the Medicaid program was incorrect. The correct percentages of ob/gyns accepting Medicaid patients as of November 1984 are: Northeast, 66.2 percent; North Central, 69.2 percent; South, 60.4 percent; and West, 63.1 percent.]

Mr. FOGEL. Although increased reimbursement might expand the choices of providers available to Medicaid-eligible women, an important goal, it would not in our opinion be the best use of limited resources. Expanding Medicaid eligibility would in our view do more to expand access to care. As I previously mentioned, for every dollar spent in providing prenatal care to high risk women, such as those we interviewed, over $3 could be saved to reduce neonatal intensive care costs.

This concludes our testimony, and we would be pleased to respond to any questions.

[The prepared statement of Mr. Fogel follows:]

United States General Accounting Office

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Testimony

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PRENATAL CARE

Statement of
Richard L. Fogel, Assistant Comptroller General
Human Resources Division

Before the
Subcommittee on Human Resources
and Intergovernmental Relations
Committee on Government Operations
House of Representatives

GAO/T-HRD-87-25

SUMMARY

More than $2.5 billion is spent annually on neonatal intensive care services in the United States, primarily for low birth-weight babies. Babies born to women who received no prenatal care are three times more likely to be of low birth weight than those whose mothers received early care. According to the National Academy of Sciences' Institute of Medicine, for every dollar spent on prenatal care for high-risk women, over three dollars could be saved in the cost of care for low birth-weight infants.

GAO interviewed 1,157 Medicaid recipients and uninsured women in 32 communities in 8 states to determine the timing and number of their prenatal care visits and the barriers they perceived as preventing them from obtaining care earlier or more often. Of the women interviewed, about 63 percent obtained insufficient prenatal care, according to the Institute of Medicine's Prenatal Care Index, because they did not begin care within the first 3 months of their pregnancy or made eight or fewer visits for care. About 81 percent of a comparison group of women with private health insurance received adequate care. For the Medicaid and uninsured women, about 12.4 percent of the babies born were of low birth weight. Nationally, about 6.8 percent of births are of low weight.

Three barriers to earlier or more frequent prenatal care predominated in virtually every demographic group of women--lack of money to pay for care, lack of transportation to the provider of care, and unawareness of pregnancy. The importance of these and other barriers differed, however, by community.

A comprehensive effort is needed to identify the primary barriers in a community, develop programs to overcome those barriers, and evaluate their effectiveness in improving access to prenatal care.

Although the solutions must be designed to meet the needs of individual communities, federal funds are available to assist states and communities in such efforts. Money spent to expand prenatal care services should be more than offset by decreased newborn intensive-care costs.

32-036 0 - 88 - 3

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here to discuss the results of our report[1] to the subcommittee on problems encountered by Medicaid recipients and uninsured women in obtaining prenatal care.

The report is based on the results of interviews with 1,157 Medicaid recipients and uninsured women and analyses of appropriate medical records to determine (1) the number and timing of their prenatal care visits and (2) the barriers they perceived as preventing them from obtaining care earlier or more often. We did our interviews and analyses in 32 communities in 8 states.

Background

According to the American College of Obstetricians and Gynecologists, every pregnant woman should begin a comprehensive program of prenatal care as early in the pregnancy as possible. For example, a woman with a normal 40-week pregnancy should see a doctor or other health care provider about 13 times. Early and continuing prenatal care plays an important role in preventing low birth weight and poor pregnancy outcomes. Babies born to women who obtain no prenatal care are three times more likely to be of low birth weight--5.5 pounds or less--than babies born to women who obtain care early in their pregnancies. Prenatal care is especially important for low-income, minority, and adolescent women, who are regarded as medically high-risk groups.

The costs of inadequate prenatal care are high, in terms of both infant mortality and increased health care costs. Nearly 40,000 infants born in 1984 died before their first birthday. The approximately 254,000 low birth-weight infants (about 6.8 percent

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[1]Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care (GAO/HRD-87-137, Sept. 30, 1987).

of all births) born in 1985 were almost 40 times more likely to die during the first 4 weeks of life than normal birth-weight babies.

More than $2.5 billion is spent annually on neonatal intensive care services, primarily for low birth-weight babies. According to the Institute of Medicine, for every dollar spent on prenatal care for high-risk women--such as those we interviewed--over three dollars could be saved in the cost of care for low birth-weight babies.

In 1980, the Surgeon General set out specific objectives for improving infant health and reducing infant mortality by 1990. One of the objectives was to reduce to 5 percent or less the percentage of babies of low birth weight. Another objective was for 90 percent of all pregnant women to obtain prenatal care within the first 3 months of their pregnancy. However, as of 1985, the latest year for which data were available, virtually no progress had been made in meeting these two objectives. For example, the percentage of women obtaining prenatal care during the first trimester was 76 percent in both 1980 and 1985.

Most Medicaid Recipients and Uninsured Women Obtained Insufficient Care

From the results of our work, it appears unlikely that the Surgeon General's goal will be met by 1990, particularly for the approximately 26 percent of women of childbearing age who lack private health insurance.[2] Of the women we interviewed, about 63 percent obtained prenatal care we considered insufficient because they did not begin care within the first 3 months of their pregnancy or made eight or fewer visits for care. About 12.4

[2]According to 1984 data, 17 percent of women of childbearing age had no insurance to pay for prenatal care and another 9 percent had only Medicaid coverage.

percent of the babies born to these women were low birth-weight babies. The national average is 6.8 percent.

Insufficient prenatal care was a problem for women of all childbearing ages, of all races, and from all sizes of communities. But those most likely to obtain insufficient care were women who were uninsured, poorly educated, black or Hispanic, teenagers, or from the largest urban areas. The percentage of Medicaid recipients and uninsured women who had insufficient prenatal care ranged from 14 percent in Kingston, New York, to 82 percent in Montgomery, Alabama. (See attached list.)

In all but two communities studied (Kingston, New York, and Troy, Alabama), a higher percentage of privately insured women obtained adequate care. Overall, 81 percent of privately-insured women studied in the 32 communities obtained adequate care compared with 36 percent of the women with Medicaid coverage and 32 percent of women with no health insurance.

Multiple Barriers to Care Found

We asked the Medicaid recipients and uninsured women interviewed what kept them from obtaining prenatal care earlier or more often. Barriers to earlier or more frequent care varied according to such factors as age, race, and size of community, with about half of the women interviewed citing multiple barriers. Three barriers predominated in virtually every demographic group of women--lack of money to pay for care, lack of transportation to the provider of care, and lack of awareness of the pregnancy. The importance of these and other barriers differed, however, by community. For example,

-- None of the women interviewed in Birmingham, Alabama, cited lack of money as the most important barrier compared with 27 percent of the women interviewed in Los Angeles. The

difference appears to be due to the availability of free prenatal care in Birmingham.

-- Transportation was more frequently named as a barrier in rural and midsized cities that lacked public transportation.

-- Over 25 percent of women in five midsized communities said lack of awareness of the pregnancy was the most important barrier to prenatal care, while less than 10 percent of women in five other midsized communities cited this barrier.

Because of such differences, programs to overcome barriers to prenatal care need to be tailored to meet the needs of individual communities. Federal funds are available to assist states and communities in such efforts. Specifically,

1. States can extend Medicaid eligibility to pregnant women with incomes up to the Federal poverty level. As of June 1987, 19 states had done so. We found that Medicaid coverage reduced (from 23 to 10 percent) the significance of lack of money as a barrier to prenatal care for the women we interviewed. The Congressional Budget Office (CBO) estimated that federal Medicaid costs would have increased about $190 million in fiscal year 1987 had all states expanded eligibility.

2. States can extend Medicaid coverage to pregnant women while their Medicaid applications are being processed. Of the Medicaid recipients who cited lack of money as a barrier to care, most said that they encountered problems in establishing eligibility. This could delay women receiving prenatal care services under Medicaid. CBO estimated that presumptive eligibility would only cost the Federal Government about $6 million over a 3-year period. As of June 1987, no states have implemented presumptive eligibility.

3. States and communities could allocate additional Maternal and Child Health Block Grant funds to prenatal care services. Such funds could be used, among other things, to fund educational and outreach services to get women into prenatal care earlier and to provide transportation services to help them get to a health care provider.

Another solution suggested by some is to increase Medicaid reimbursement rates for maternity services to encourage more private-practice physicians to accept Medicaid patients. Few of the women we interviewed, however, had problems finding a health care provider to see them. Specifically, about 61 percent obtained care at a hospital or public health clinic. Only 2 percent of the women who obtained insufficient care cited difficulty in finding a doctor as the most important barrier to earlier or more frequent care. In addition, the participation rate of OB/GYNs in Medicaid is low--ranging from 6.2 percent in the South to 10.9 percent in the West in 1984. Although increased reimbursement might expand the choices of providers available to Medicaid-eligible women--an important goal--it would not, in our opinion, be the best use of limited resources. Expanding Medicaid eligibility would, in our view, do more to expand access to care. As I previously mentioned, for every dollar spent in providing prenatal care to high-risk women such as those we interviewed, about three dollars could be saved in reduced neonatal intensive care costs.

This concludes my statement. We would be pleased to answer any questions.

Proportion of Medicaid Recipients and Uninsured Women Having Insufficient Care, by Community

Community	Percent of women having insufficient care	Total no. of women interviewed
Montgomery, Alabama	82	22
Brunswick, Georgia	79	24
Savannah, Georgia	78	23
New York, New York	76	84
Selma, Alabama	76	45
Los Angeles, California	75	212
Huntsville, Alabama	74	19
Chicago, Illinois	72	65
Atlanta, Georgia	69	95
Bakersfield, California	69	39
Troy, Alabama	67	24
Charleston, West Virginia	66	38
Columbus, Georgia	65	26
Buffalo, New York	63	16
Birmingham, Alabama	57	35
Clarksburg, West Virginia	56	16
El Centro, California	53	19
Bluefield, West Virginia	51	39
Ukiah, California	50	18
Sacramento, California	50	26
Poston, Massachusetts	49	51
Americus, Georgia	48	23
Carbondale, Illinois	47	38
Mattoon, Illinois	47	17
Rockford, Illinois	44	34
Peoria, Illinois	42	19
Bangor, Maine	40	10
Auburn, New York	38	16
Syracuse, New York	38	16
Huntington, West Virginia	24	25
Augusta, Maine	22	9
Kingston, New York	14	14
Total	63	1,157

Mr. WEISS. Thank you very much, Mr. Fogel.

It is shocking to me to learn that 63 percent of the poor women interviewed by GAO received insufficient prenatal care. I understand that the numbers are even more staggering in some areas, as you have indicated. Would you be more specific?

Mr. FOGEL. I would be glad to, Mr. Chairman. Attached to our testimony is a table that appears in the report. And we have ranked the 32 cities in terms of the percent of women having insufficient care. As I mentioned, 82 percent of the women in Montgomery, AL, had insufficient care. Brunswick, GA, was 79 percent; Savannah, GA, 78 percent; New York City, 76 percent; Los Angeles, 75; Chicago, 72; Atlanta, 69; Bakersfield, CA, 69. I am just going down the list. Clarksburg, WV, 56 percent; Eureka, CA, 50 percent; Sacramento, 50 percent; Boston, 49 percent. It starts dropping off fairly significantly when you get to the last three on the list. Huntington, WV, only had 24 percent with insufficient care; Augusta, ME, 22 percent; and Kingston, NY, 14 percent.

Mr. WEISS. Before we go further, perhaps you would again define the terms that were used, because I think that at first it is hard to pick up the distinctions.

Mr. FOGEL. Sure.

Mr. WEISS. Would you tell us the distinction between insufficient, inadequate, and intermediate care?

Mr. FOGEL. Yes. We used the Institute of Medicine prenatal care index, which classifies the adequacy of prenatal care by the number of prenatal visits in relation to the duration of the pregnancy and the timing of the first visit.

Using these criteria, we said that adequate care occurs if it begins in the first trimester and includes nine or more visits for a pregnancy of 36 or more weeks. So, anything less than that is insufficient, which is a combination of intermediate and inadequate care. Intermediate care is if it begins in the second trimester or includes five to eight visits for a pregnancy of 36 or more weeks. And inadequate care is if the visits occur in the third trimester or include four or fewer visits for a pregnancy of 36 or more weeks. So, the worst cases would be those cases where women did not see a health care provider until the third trimester and had four or less visits. But we also include as insufficient a woman who saw a physician beginning in the second trimester or had eight or fewer visits.

Mr. WEISS. So that when you have those statistics, as terrible as they are, it doesn't necessarily mean that they received no care at all, but they received—they had an inappropriate number of visits to provide protection for themselves and for the child they are pregnant with. Is that right?

Mr. FOGEL. That's correct.

Mr. WEISS. Now, I know that GAO studied hospitals that are somewhat typical of those serving poor women in different regions of the country. And I think you said that GAO found that 25 percent of uninsured women had four or fewer prenatal visits, and that many do not have their first visit until the fifth month of pregnancy or later.

If your findings are representative of the Nation—and I realize that GAO can't claim with certainty whether they are or not—how would that translate in the numbers of poor pregnant women who

receive inadequate prenatal care in the United States and those receiving intermediate levels of care? Would you be able to make that kind of projection?

Mr. FOGEL. I think we would prefer not to because we just did not take a valid, random national sample. We would be glad, though, to take a harder look at that information and see if we can't get back to you with some extrapolations.

Mr. WEISS. And submit it for the record?

Mr. FOGEL. Yes.

Mr. WEISS. We would appreciate it if you could do that.

[The information follows:]

The wide variation in the percentage of women obtaining insufficient care in the 32 communities studied—from 14 percent to 82 percent—coupled with the method used to select communities precludes any extrapolations of the data. Because problems were identified in all 32 communities, however, we believe it is likely that a problem exists for Medicaid recipients and uninsured women in virtually every American community. What will vary is the extent of the problem and the types of barriers Medicaid recipients and uninsured women face.

Mr. FOGEL. One thing I would want to say that might help some, though, is that we picked the eight States, and then we very consciously tried to look at communities that included some of the largest cities in States, some medium size cities, and some rural and smaller cities. Then, in looking at the hospitals in the communities, we tried to look at those that were serving basically, as you said, Medicaid and uninsured women. And we feel fairly confident that the information we found in these 32 communities is sufficient to help policymakers look at the extent to which we have a problem in this country with providing adequate prenatal care.

Mr. WEISS. So that although you may not with absolute scientific certainty be able to project national conditions on the basis of these statistics, you can say that generally they reflect fairly accurately what the conditions would be nationwide.

Mr. FOGEL. That's my belief, yes.

Mr. WEISS. Now, according to your report, three major barriers reported by poor women who receive insufficient prenatal care are lack of money, lack of transportation to health care providers, and third, the fact that they didn't realize that they were pregnant. Many of the women who didn't realize that they were pregnant were young and unmarried. Now, once they realized that they were pregnant, was prenatal care delayed for other reasons? Can you tell us that?

Mr. FOGEL. I would let either Mr. Linz or Mr. Landry, whoever might know the statistics better than me, answer that.

Mr. LANDRY. We found about half of the women who answered with that barrier listed one or more other barriers to their receiving prenatal care. Basically these other barriers were spread out. The largest one was that 14 women stated they did not want to think about being pregnant; 11 stated that they were afraid to find out they were pregnant; 10 women stated they didn't have enough money to pay for their visits; and on down to 2 or 3. But those were the three largest secondary barriers that these women stated.

Mr. WEISS. OK.

Mr. FOGEL. I think that tends to indicate that for that group of women it is very important to have good education programs and

outreach so they understand basically what is going on in their lives and how to react to different situations.

Mr. WEISS. Now, according to your report, about 15 percent of women obtaining inadequate prenatal care said they had a long delay for appointments. About 15 percent said they didn't—well, let me yield at this point to Mr. Lightfoot, and I will ask that question later on.

Mr. LIGHTFOOT. Thank you, Mr. Chairman. Isn't it terrible when your life is controlled by a little red light?

Gentlemen, thank you for coming this morning.

Your report examines some barriers to prenatal care among women who live in rural areas and urban areas. And from that investigation, what, if any, differences did you find between those areas in terms of access to prenatal care?

Mr. LINZ. There were significant differences by community, as Mr. Fogel went through a little bit earlier. It ranged anywhere from 82 percent in Montgomery, AL, to 14 percent in Kingston, NY. The areas where there was less insufficient care were generally in New England or rural areas in New York State.

Mr. LIGHTFOOT. I noticed that the closest State to my State of Iowa in your survey was Illinois, which would be pretty typical of our part of the country I think. Did you make any comparisons between Midwest rural as compared to east coast rural, for example?

Mr. LINZ. In Chicago it was 72 percent. Most of the other Illinois cities we went to were all grouped around 45 to 47 percent insufficient.

Mr. FOGEL. We do have some tables in the back of the report that break down the barriers for prenatal care by hospital where we interviewed the women in each State. And what we could do for you—and I would be glad to provide this in the next couple of days—is to take a look. Some of this is pretty detailed. It really begins on page 139 if you have the report. Appendix XII shows barriers by hospital and shows a breakdown of what was of particular concern to people in urban, midsize, and rural areas.

One thing we did find is that in midsize and in smaller communities, lack of transportation was more of a barrier than it was in urban areas.

Mr. LIGHTFOOT. Urban, being available.

Mr. FOGEL. Yes.

[The information follows:]

Women interviewed in midwest rural areas were more likely than women interviewed in east coast rural areas to cite logistical/health services barriers to care. For example, among women interviewed in Carbondale and Mattoon, Illinois, who had received insufficient care, one or more cited the following barriers as the most important reason for their not obtaining care earlier or more often:

A lack of transportation to the provider's office.

A lack of providers in the area.

An inability to find a provider to care for them, and

A belief that the wait in the provider's office was too long.

None of the women receiving insufficient care in east coast rural areas (Augusta, Maine, and Kingston and Auburn, New York) cited these barriers. However, women in east coast and midwest urban areas had several barriers in common. For example, a lack of money to pay for care was cited as the most important barrier by 4 of the 18 women receiving insufficient care in Carbondale, by 1 of the 8 women receiving insufficient care in Mattoon, and by 2 of the 6 women receiving insufficient care in Auburn. Similarly, 4 of the 18 women in Carbondale and 1 of 2 women in Kings-

ton who received insufficient care claimed that not knowing they were pregnant was the most important barrier to their receiving earlier or more frequent care.

Mr. LIGHTFOOT. Now, with the three categories, urban, midsize, and rural, what criteria did you use to determine these categories in terms of population? Was rural 5,000 and below, or what were your figures?

Mr. LANDRY. Rural areas were those that were not part of an MSA as defined by the Census Bureau. That would be cities with less than 50,000 population. Generally the cities we picked had populations of 10,000 to 30,000 in the county. Midsize cities tended to be about 100,000 to maybe close to a million. And then, of course, the five largest urban areas, Atlanta, Boston, New York, Chicago, and Los Angeles, were the major urban centers in each State.

Mr. LIGHTFOOT. The reason I ask—and I am not being critical at all of your criteria, but I'm trying to get a handle on it. For example, my district is 27 counties. It's roughly a third of the State of Iowa. I have one community that is right at 50,000, and below that, if you find 5,000 people in a group, you have run onto one heck of a goings-on of some kind. And we have some very serious problems with our rural hospitals now, primarily because of the scarce population, which goes back to what I had said earlier. Many times I think the formulas we use identify where people are but not necessarily where the problems are because costs are very high to us, and we don't have a large number of people to spread these costs around.

Very quickly before my time runs out, in your investigation of access to prenatal care, did you run into any indications that the problem we are facing with medical malpractice have made doctors reluctant to provide prenatal care to women?

Mr. FOGEL. We have looked very extensively at the medical malpractice problem in the United States for numerous committees and Members of Congress. In this particular job, we did not go out and ask physicians—in this case, ob/gyns—whether they were willing to accept Medicaid patients or not because of the malpractice problem. However, I would point out, as we said in the statement, the participation rate of ob/gyns in Medicaid is very low. It ranged from about 6 percent in the South to about 11 percent in the West.

[Subsequent to the testimony, GAO learned that the study it cited noting participation rates of ob/gyns in the Medicaid program was incorrect. The correct percentages of ob/gyns accepting Medicaid patients as of November 1984 are: Northeast, 66.2 percent; North Central, 69.2 percent; South, 60.4 percent; and West, 63.1 percent.]

Mr. FOGEL. We have done a lot of work looking at the physicians' specialties that have had claims filed against them for malpractice suits and what has been paid out. Ob/gyns, for example, represent about 5.2 percent of all physicians in the United States. Yet, they were involved in 12.4 percent of all medical malpractice claims that were filed in 1984, based on a valid, random national survey of all claims filed in 1984.

Also, in terms of payouts of those involved in claims, about 54 percent of all the ob/gyns had claims against them.

I would be glad to provide copies of our reports on this issue to both the chairman and you so you could get a better picture of the

medical malpractice problem that ob/gyns face. But it is a problem for that specialty throughout the United States.

Mr. LIGHTFOOT. I would appreciate that. I think that will be very helpful to both of us.

I have another commitment I have to run to. I'll try and get back before we are finished. But thank you, gentlemen, for coming this morning.

Mr. WEISS. Thank you very much, Mr. Lightfoot.

As I recollect reading the executive summary of your report, you seem to indicate that women in rural areas have less of a problem of access to care than women in urban areas. Would you expand on that?

Mr. LINZ. I think we have found that there were more problems in the major metropolitan areas than in either midsize or rural areas.

Mr. WEISS. Right. Now, tell me, if you can, what is the basis for that conclusion? What were the differences?

Mr. LINZ. I think it is more the lack of money as a barrier in some of the larger areas, and transportation was a more significant barrier in the rural areas. Some of the awareness and the attitudinal barriers I think were more prevalent in the larger communities.

Mr. WEISS. It is an important area of concern for all of us, and certainly in making suggestions or recommendations as to national policy. I would welcome your submitting for the record some amplification of those conclusions so that we would have something more concrete to go on. OK?

Mr. FOGEL. Yes. We would be pleased to do that.

[The information follows:]

Even though women in the largest urban communities were more likely to obtain insufficient care, we cannot cite specific reasons for this situation because each community was unique in terms of the barriers women faced in obtaining prenatal care. Our data show that women in similar-sized communities do not necessarily perceive the same barriers to care. For example, among women who received insufficient care, a lack of money was cited most often as the most important barrier in Los Angeles, while women in Atlanta most often claimed they had encountered no problem. Similarly, in the rural community of Brunswick, Georgia, over half the women receiving insufficient care cited a lack of money as the major barrier, while women in Troy, Alabama, most often cited a lack of transportation. Further, most of the women we interviewed who had obtained insufficient care faced multiple barriers to care. Specifically, 65 percent of those in rural areas cited two or more barriers, as did 60 percent in the largest urban areas and 59 percent in midsize communities. The community-by-community variation in barriers, as well as the fact that women face multiple barriers, suggests that solutions must be individually tailored; what works in one urban or rural area may not be appropriate for another similar-sized city.

We did note that the problem of insufficient care was more significant in some demographic groups. Specifically, we found that women who were poorly educated, uninsured, Hispanic, black, or under 20 years of age were most likely to obtain insufficient care. Higher percentages of these women were interviewed in the largest urban areas, even though the total number of interviews was fairly evenly distributed among women in the largest urban, other urban, and rural areas. Among all women interviewed, 75 percent of those who had less than an 8th grade education, 56 percent of the uninsured, 85 percent of the Hispanic women, 42 percent of the black women, and 39 percent of the teenagers (19 years of age or less) were in the largest urban areas.

Mr. WEISS. Good. Thank you.

Now, according to your report, about 15 percent of women obtaining inadequate prenatal care said they had a long delay for appointments. About 15 percent said they didn't know where to go for care. And about 15 percent had difficulty finding a physician or health care provider who would accept them as a patient. Are these overlapping responses, or should these three responses be added together to determine problems in finding health care providers? Because, if so, it becomes a rather frequent response and may suggest the need to increase Medicaid reimbursement rates.

Mr. FOGEL. We asked them very specifically what barriers they felt they had. And they were able to make a distinction among those three. I think cumulatively, if you look at them, you could arrive at the conclusion you did. However, most of the women that we talked to did not say that trouble finding a provider was the most important barrier to care, only 2 percent. And I don't want to minimize for those 2 percent the seriousness of the problem.

[Mr. Fogel subsequently clarified his response for the record: Finding a provider was the most important barrier to care for 2 percent of women obtaining intermediate care and 4 percent of those obtaining inadequate care. While finding a provider was not the most important barrier most women faced, it was a significant problem with 15 percent of women who received inadequate care saying they had a problem.]

Mr. FOGEL. But where we come down on increasing the Medicaid reimbursement to the ob-gyns is that it would be desirable, if you are looking at a limited amount of money that we could put into this program to expand prenatal care, to see the States increase the Medicaid eligibility level so that at least they could bring in women up to 100 percent of the poverty level.

And unfortunately, we have a chart in the report that shows that none of the States that we were in, if you even looked at medically needy, let alone AFDC eligibility, had their eligibility at 100 percent of the Federal poverty level. Well, I take that back. California's medical needy eligibility standard was almost 109 percent of the poverty level. But Georgia's was only 45, Illinois' was only 60, New York was 81, Massachusetts was about 87, and Alabama didn't even have a medically needy program.

So, we think it is more important to get those States that haven't to get the eligibility level up to a minimum of 100 percent of the poverty level. And it might be more beneficial to do that initially than to increase the amount of money for ob/gyns if you are dealing with a limited supply of funds.

Mr. WEISS. Well, the reason I asked the question is because I take the statistics that I just cited about the cumulative 45 percent as reasons for failing to obtain adequate prenatal care and then couple that with the figures that you cited before that the percentage of ob/gyns who accept Medicaid patients ranges from as low as 6 percent to as high as 11 percent. Were you able to determine or did the study try to determine what the reasons were for that low rate of involvement in the Medicaid program?

Mr. LINZ. The problem I don't think is limited to prenatal care. There is a low Medicaid participation rate for all medical specialties. It may be more severe for ob/gyns, but there are nursing

homes that won't participate. Medicaid reimbursement rates are low.

Mr. WEISS. Well, that's right. But again, I don't have the figures at my fingertips. But I would think that the 6 percent to 11 percent range of participation is extremely low. And I would think that you would want to get some determination from those doctors or from the specialty itself as to the reasons why. I think you indicated that malpractice may be one of the reasons. But I would assume that Medicaid would be one of the reasons as well. And the question is how significant a reason is it.

Mr. FOGEL. I would agree with you. I would assume it would be. We don't have the answer as to how significant a factor it is in those physicians' decisions not to participate in the program.

Mr. WEISS. Now, you recommend in the report that there be better access to free prenatal care, which you state would be cost effective. Do you think that such care could actually pay for itself in terms of money saved for neonatal intensive care and money spent on special services for physically and mentally disabled children?

Mr. FOGEL. We have not in the GAO done an independent benefit cost study, but the studies we have reviewed say it is cost beneficial. Primarily we are relying on the Institute of Medicine's study which was very conservative. Other studies have estimated that you could save from $2 to $10 in neonatal costs by putting money into prenatal care.

The House Budget Committee used the Institute of Medicine analysis. And so, they used the 3.38 to 1 ratio. So, we are willing to stick with that and believe that it would be cost beneficial to put more money into prenatal care. You are going to have healthier babies that are going to have less problems. And especially if you are dealing with women who are either on Medicaid or don't have insurance, and you look at their socioeconomic status, as we tried to do, you can assume that the healthier their children are the better probability is they can learn better, get a better education and really develop to the fullest extent later on in life.

Mr. WEISS. You indicated earlier that Birmingham, Alabama provides free prenatal care. Is that a State funded, local funded, or federally funded program? Who pays for that?

Mr. FOGEL. Well, it's a local program, but from previous work we have done, looking at how all the block grants that were implemented in States as a result of the 1981 Reconciliation Act, it was very clear to us, for example, in looking at the Maternal and Child Health block grant and in the Preventive Health Care block grant, that once the Federal moneys go to the State and then down to the local level, there is a lot of comingling of funds. So, although it was a local decision, my assumption is that there probably is some Federal money through some of the block grant programs helping the Birmingham community fund that program.

Mr. WEISS. But it is quite clear that the free prenatal care program ultimately ends up saving money for all three levels of government.

Mr. FOGEL. I would agree, yes.

Mr. WEISS. Right. And the statistics are really very, very impressive, and it seems to me that again all three levels of government

ought to be encouraging the provision of free prenatal care. That comes through very clearly from the report that you have submitted—that it is all gain and no loss, and it is all very significant gain for everybody all around.

Mr. FOGEL. Well, I would personally tend to agree with you. CBO showed that it would only cost $190 million to the Federal Government if all of the States raise their eligibility standard up to 100 percent of the poverty level. And in the context of overall budget decisions, that is not a lot of money to spend up front to get a very good return on that investment later on.

Mr. WEISS. The report also criticizes the lack of information about the effectiveness of prenatal programs that receive Federal funds. The California Job Access Project seems to be an exception. And as a result, California has made major changes in their prenatal care programs.

What kinds of evaluations do you think are needed nationwide?

Mr. FOGEL. Well, first of all, what we would like to see is for HHS to expand its efforts to encourage the States to report on the results of specific projects. We would like to see HHS then take that information and through a series of efforts look at best practices and disseminate those results to other people. So, the type of evaluations we want first is more to be done to assess what is going on at the local level so that other communities and States can benefit more from the experiences in other places of the country.

And there has been, unfortunately, in the last 6 to 7 years a dearth of good evaluation information on what is happening in a lot of these programs around the country. There are some very good things happening in some local communities, but other communities don't know about it. And we would like to see the Health and Human Services Department take a little more aggressive stance in trying to collect and disseminate this information.

Mr. WEISS. The report also suggests the need for expanded technical assistance to communities in reducing barriers to prenatal care. What type of technical assistance is currently available from HHS?

Mr. FOGEL. They have specific programs through the public health service where they will go out. That would be a good question to ask Dr. Helms in more detail.

But the type of technical assistance we have in mind is sort of reflected in what we did in our report. It gets to the issue of helping the community really understand what the barriers are in the community, and then helping it design a program to really attack those barriers. In other words, just as we pointed out, with some rural communities some of the people in those communities thought that lack of knowledge was a problem. But in other rural communities that wasn't a problem. So, the community has to be able—and again this could be with the help of HHS or funding things through the State university systems—to design some studies to really find out what the barriers are so it can focus the expenditure of funds, not just attack it broadly, but really zero in on what the key problems are to address.

Mr. WEISS. On a similar note, the report criticized the lack of dissemination of information about studies that are conducted with

Materna' and Child Health Services block grant funds. Does the current law provide money for dissemination of that information?

Mr. FOGEL. Yes, it does.

Mr. WEISS. Well, again, I want to express my appreciation to you and to the General Accounting Office for the excellent report which you have provided and for your participation in today's hearing. We may be submitting additional questions to you in writing from either the subcommittee or individual members of the subcommittee, and we would appreciate your response to those questions. And again, we want to thank you for your participation.

Mr. FOGEL. Thank you, Mr. Chairman. We enjoy working with the subcommittee on this and all the other projects.

Mr. WEISS. Thank you.

I would like then to welcome our third panel, which will include Dr. Charles Johnson, director of the Public Policy Resources Laboratory of Texas A&M University; Sarah Brown, study director of the Committee on Prenatal Care of the Institute of Medicine; and Dr. Stephen Havas, acting commissioner of the Massachusetts Department of Public Health. If I mispronounce any names, please forgive me and correct me.

Before you sit down, if each of you will raise your right hands.

Do you affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

Let the record indicate that each of the witnesses has responded in the affirmative.

Let the record also indicate that Ms. Hess was also sworn in. Would you give us your full name?

Ms. HESS. My name is Catherine Hess. I am also with the Massachusetts Department of Public Health.

Mr. WEISS. Fine. Thank you very much.

Dr. Johnson, I think that we will begin with you. And again, our appreciation to you for the work that you have done and for coming before the subcommittee today.

STATEMENT OF CHARLES D. JOHNSON, PH.D., DIRECTOR, PUBLIC POLICY RESOURCES LABORATORY, TEXAS A&M UNIVERSITY

Dr. JOHNSON. Thank you, Mr. Chairman.

I am Dr. Charles Johnson, and I'm very pleased to testify on this extremely important issue. I am the director of the Public Policy Resources Lab and a full professor at Texas A&M University.

For the past 2 years, I have been involved with a 10-State project, the results of which are only just now available. The project was focused on the identification of unmet need for prenatal care. It was funded by the Division of Maternal and Child Health, and a detailed account is available in my written statement. I will summarize that more lengthy statement in the next few minutes.

States included in the effort were Arizona, California, Michigan, New Mexico, New York, Oklahoma, Oregon, Rhode Island, South Carolina, and Texas. These States account for approximately 38 percent of all births in the Nation and a similar proportion of infant deaths. The project grew out of the need of these States to accurately identify the number of women having difficulty access-

ing care, and also in reaction to the inadequacy of available data for providing an answer to that question.

In terms of specific methodology, we surveyed women after they had delivered but were still in the hospital. The women were asked a number of questions about the prenatal care they received, how they paid for care and so forth.

There were several hundred hospitals involved across these 10 States, as you might imagine, as well as State medical societies and hospital associations. All of these organizations were extremely helpful in this effort. I think the support of these groups is reflected in the fact that most of these States had over 90 percent hospital participation in the project. Participation rates by the women themselves were in the 80 percent range across the States.

I might point out parenthetically that in a study of this type, a 50-percent rate is regarded as very good. Consequently, we were delighted with the support and response. There were approximately 13,000 total respondents in this study.

Based upon this high response rate and the particular questions asked, we feel that this is probably the best current source of information on how pregnant women of various income levels pay for the prenatal care they receive. The most important information is included in the tables at the conclusion of the written statement. These tables show for each State the percentage and number of women who have neither insurance nor Medicaid at each of the various poverty levels.

To summarize the results quickly, across the 10 States we estimated that there are approximately 158,000 women living in poverty—that is to say, below the 100-percent poverty level—who have neither Medicaid nor private insurance to pay for prenatal care. At the 185 percent poverty level, this number moves to 251,000. These are need levels which are both real and substantial, but they are also within the realm of numbers that can be addressed.

The solution seems to be a broadening of the availability of prenatal care for these women. We project that if you were to serve every woman in need across these 10 States, provide them with a $400 package of prenatal care services, the costs would range from $63 million to $100 million depending on the eligibility cutoff selected, whether it was 100 or 185. Full services, including delivery, would range from $190 million to $300 million for this same group.

As has been indicated in prior testimony, I think we are already paying the cost of not having done this, by way of extraordinary neonatal intensive care costs and additional costs beyond the first year in terms of special education, handicapped services, and additional health care.

So, in conclusion, I feel that this is an important problem, but it is also a problem with a solution. And I am hopeful that the solution will be acted upon. Thank you.

[The prepared statement of Dr. Johnson follows:]

UNMET NEED FOR
PRENATAL CARE
SEPTEMBER 30, 1987

Charles D. Johnson, Ph.D., Director
Public Policy Resources Laboratory
Texas A & M University
College Station, Texas

I. INTRODUCTION

This report describes the procedures and results from the Multi-State Prenatal Needs Determination Project (MSPND). The primary objective of the MSPND project was to provide participating states with the methodology and technical assistance necessary for developing estimates of unmet need for prenatal care in their state. As will be discussed in more detail later, the primary method employed involved a sample survey of postpartum women delivering in all hospitals with active obstetrical units. This general objective entailed a number of specific activities, including collecting information describing existing archival data systems, preparing a literature review concerning maternal and child health needs assessment, providing technical assistance and conducting site visits, hosting a national conference, and developing estimates of unmet need for prenatal care through the construction and analysis of a database employing data elements common to the postpartum surveys in each state.

II. PRIOR RESEARCH

Direct surveys of the target group of interest have several advantages over social indicator (e.g., vital statistics and census data) approaches (Warheit and Bell, 1983). First, the investigator undertaking the needs assessment has the ability to select variables that directly reflect the goals of the needs assessment. Unlike social indicator approached, the needs assessment can include all variables of concern that may impact upon eligibility and geographic distribution of need, thus avoiding the use of frequently inaccurate "proxy" measures. Secondly, direct survey data is collected when needed, rather than according to a schedule unrelated to program needs. The primary temporal constraint pertains to the rapidity with which the survey effort itself can be implemented and completed. Third, because a single comprehensive database is created from a survey needs assessment, it is easy to examine relationships among different variables, which is a major shortcoming when simultaneously employing two social indicator databases.

The major disadvantage of direct surveys are cost and effort, which may account for their relative scarcity. Also, when conducting direct survey needs assessments it is important to establish sample representativeness. The burden of documenting sample validity does not exist with many social indicators because they typically reflect the population experience. Nevertheless, the increased flexibility and accuracy of the data produced by direct surveys may, in many instances, justify the additional effort and expense needed to collect the data and establish sample representativeness.

III. SITE VISITS AND CONSULTATIONS

A major aspect of MSPND activity was the task of visiting each of the participating states. An initial purpose of the site visits was to establish linkages in communication between the states and MSPND staff. Site visits provided an opportunity for MSPND staff to confer with key MCH leaders in each state, to review existing data systems, and to begin to formulate an understanding of local and regional issues and problems.

The results of the initial visits to the states was very encouraging. A consensus around the direct survey methodology seemed to quickly emerge. In fact, in many states the initial site visit included specific discussion of the survey instrument, garnering support of the hospital association and other key organizations, and preliminary development of sampling strategies matched to particular states' situation. Typically, additional telephonic consultation occurred following the site visits. It was important to provide states with necessary information for further refinement of survey activities.

IV. THE SURVEY INSTRUMENT

In order to adequately assess unmet need, it is important to include items on a variety of demographic and health service variables within the survey. Demographic variables, such as age, race and education should be included in order to describe the characteristics of women in need, as well as to permit comparisons with population based vital data. Information concerning income, source of payment for care, and family size is critical when considering need for means tested prenatal care programs. Income and family size can be used to compare poverty level status. Source of payment for care can be used to discern the level of Medicaid utilization, coverage by private health insurance, and those not having access to third party payment systems. Information concerning geographical locations, such as zip codes and county, is important for determining the location of unmet need. Finally, information concerning prenatal care, such as number of prenatal visits and when care began, is important for developing care profiles for the subgroup in need. The collection of data of this type can permit a more precise specification of women in need of care. In the original (i.e., 1984) Michigan experience, it was possible to separate women who had insurance from women who were on Medicaid or women who fell between these two sources of care. In this way, a clearly underserved group was identified, substantial information about the demographic characteristics of this group and their difficulties in accessing care were also available.

Obtaining a representative sample and specifying survey administration procedures were important data collection considerations. The survey plan, as introduced to the participating states, called for administering the instrument to all women delivering in obstetrical units within a specified seven-day time interval.

A pragmatic step-by-step methodology, for conducting a maternal service needs assessment survey was developed and provided to states during site visits. This document, along with assurances of the low cost and moderate effort involved, were helpful in convincing states of the value of this method. Figure 1 represents a flow chart of the survey methodology process. These materials were used during site visits to outline to participating states the exact procedures necessary to conduct a needs assessment survey. Other technical assistance materials included: a step-by-step list of survey procedures, examples of survey materials mailed to hospitals, major points covered in hospital cover letters, instructions to hospital staff for collecting completed questionnaires, contact person postcard, transmittal sheets, follow-up call logs, protocols for conducting hospital follow-up call, and a problem solving checklist.

Figure 1

Process Flow Chart

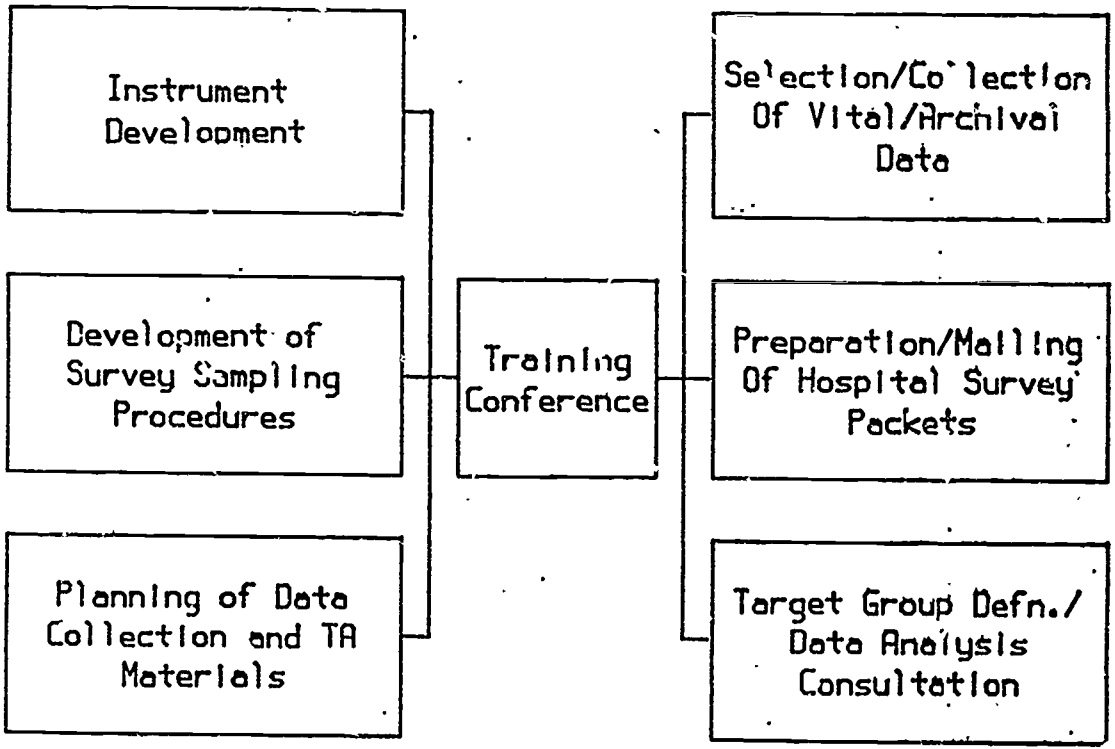


Figure 1

Process Flow Chart

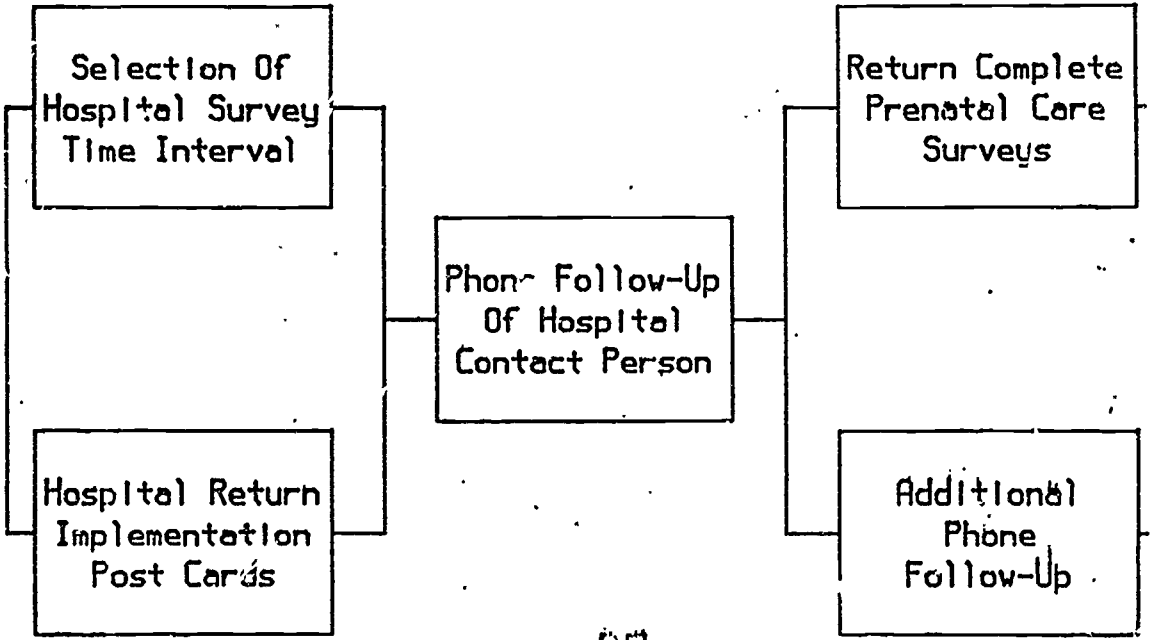
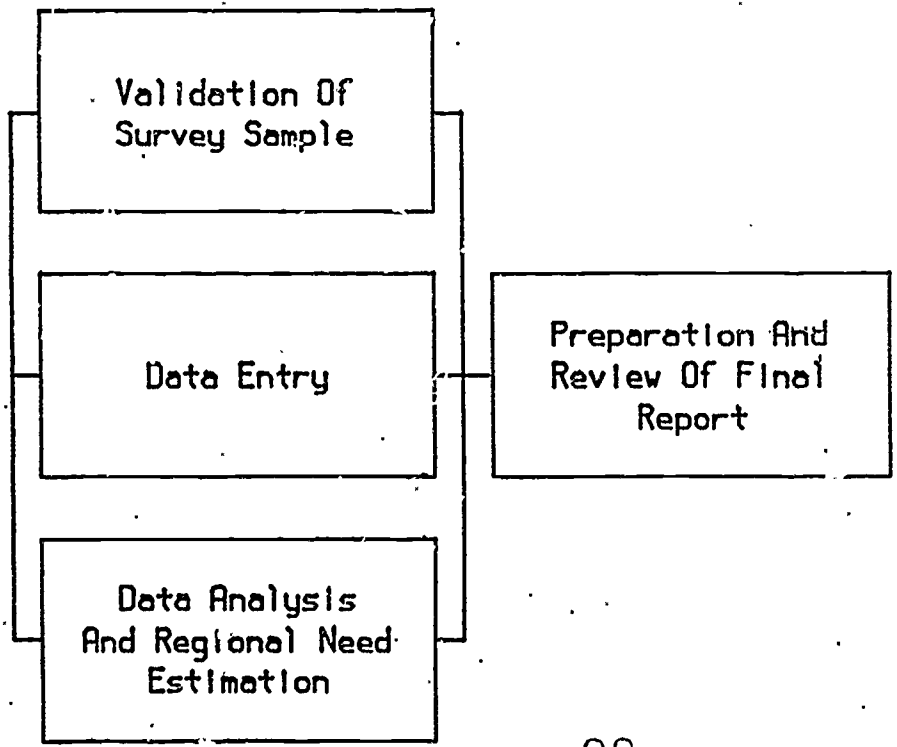


Figure 1
Process Flow Chart



V. SUMMARY OF CS SURVEY IMPLEMENTATION

The ten participating states included: Arizona, California, New Mexico, New York, Oklahoma, Oregon, Rhode Island and South Carolina. Table 1 provides a summary of survey implementation. For each state in the MSPND project several important issues are illustrated. These issues included state specific purposes for the survey, the survey instrument, key organizational support, timeframe, sampling strategy, hospital and patient participation, representativeness, and data entry and analysis.

Although there was some variation regarding purposes of the survey among states, several primary themes emerged: assessing need for specific MCH service programs, providing information for use in legislative deliberations, collecting data for use in MCH block grant applications, providing new information about the barriers to accessing prenatal care and learning about particular high risk subgroups of pregnant women.

Several states lengthened the questionnaire beyond the 17 core questions pertaining to access in order to gather additional information concerning issues of particular interest and importance. There was considerable overlap among the non-core questions. Commonly asked non-core questions included items about smoking, diet, reasons for seeking, postponing or stopping care, social support, pregnancy intention, ancillary services received, transportation obstacles, participation in other MCH programs, general health status, opinions concerning the importance of prenatal care, and perceptions concerning barriers to receiving timely and appropriate care.

With regard to sampling strategy, most states chose to implement seven-day sampling plans. To some extent, the amount of time need to achieve stable unmet need estimates, with small confidence intervals, is determined by the total number of births. Therefore, the state of California elected to collect only two days of data rather than a full week. Rhode Island for at least one major hospital, elected to collect two full weeks worth of data in order to increase the stability of unmet estimates. Some states also employed additional criteria for sample selection. These criteria typically focused on eliminating from the sample hospitals that had a small number of births per year. Oregon excluded hospital that had less than two births per month, and Arizona only included hospitals with 100 or more deliveries per year. Other variations on sampling strategy included Oregon's efforts at capturing out-of-hospital births, the quota sampling of South Carolina, and the stratified probability sampling employed in Texas.

The observed hospital and patient participation rates contributed to a positive view of the feasibility of the survey methodology. The hospital cooperation rates were largely in the 90's and ranged from 74% to 100%. Military hospitals generally declined participation, but were not included in the denominators when calculating participation rates because these hospitals were viewed as outside the public health system. Patient participation rates were also high, generally falling in the 80's. Patient rates ranged from a low of 74% in New York, to a high of 94% in Rhode Island. These high levels of participation suggest that hospitals will cooperate with a needs assessment effort of this type, and that postpartum women in hospitals represent an excellent access point for the collection of maternity care data.

The match between sample statistics and population parameters suggested good sample representativeness. The differences between samples and populations that were noted indicated that women of low education status, younger age, and having inadequate prenatal care patterns tended to be slightly less likely to respond to the survey. The under representation of these groups would serve to create a conservative bias among estimates of unmet need (i. e., the estimates reported are probably less than the actual need). Some states elected to compare samples to the entire population of births for an entire year, while others selected population based time periods that more closely matched the actual survey time period. Comparison to a full years worth of births probably better accounts for seasonal variations in births. These various activities are summarized in Table 1. Overall, the available evidence indicates that the samples selected within the various states are representative of the population of women delivering infants in that respective state.

TABLE 1

Summary of Survey Implementation

State	Purpose	Survey Instrument	Key Organizational Support	Time Frame	Sample	Hospital Participation	Patient Participation	Representativeness	Data Entry and Analysis
Arizona	Provide need estimates for Perinatal Care Program; Assess characteristics of women receiving later or no prenatal care	33 items, includes items on barriers to care, ancillary services, smoking, satisfaction with services; English and Spanish translations.	Hospital association endorsed effort; included notice about project in newsletter distributed to all hospitals	June 15, 1986 to July 15, 1986	All hospitals with >100 deliveries per year; seven-day sample	51 participating hospitals yielding a 91% cooperation rate	N=392, reflecting 82% participation rate	Excellent sample-parameter match on age, race, and marital status	Data entry, verification and analysis performed by MSPHD
California	Provide need estimates for Community-based Perinatal Services Program; Assess care patterns of Southeast Asian women	20 items, includes great detail on race and ethnicity, and a checklist of barriers to care	Supported by both North and South Hospital Associations and the State Medical Society	Surveys mailed on January 5, 1987	Stratified random sample of two days of the week at all hospitals with active OB units; stratification based on hospital size (i.e., number of births per year)		N=2,026, reflecting participation rate		Data entry, verification and analysis performed by MSPHD; California DHS provided with copy of raw data file

TABLE 1
(Continued)

Summary of Survey Implementation

State	Purpose	Survey Instrument	Key Organizational Support	Time Frame	Sample	Hospital Participation	Patient Participation	Representativeness	Data Entry and Analysis
Michigan	Provide enrollment targets for Prenatal Postpartum Care Program	33 items, includes additional items on transportation and minor status	Supported by Michigan Hospital Association, and Michigan Osteopathic Hospital Association	January 1, 1986 to January 31, 1986	Seven-day sample from all hospitals with active OB units	124 participating hospitals reflecting a response rate of 95%	N=1,892, reflecting 84% participation rate	No sample-population differences on number of prenatal visits, proportion no prenatal care; maternal education and age	Performed by MSPHD
New Mexico	Assess characteristics of women receiving late and/or inadequate prenatal care	20 items, including ones on WIC participation, breastfeeding, and weight gain. English and Spanish translations.	New Mexico Hospital Association letterhead used in mailing to hospitals; Support also provided by New Mexico Chapter of the Academy of Obstetricians and Gynecologists, New Mexico Pediatric Society, and New Mexico Chapter of the American Academy of Family Physicians	April 15, 1986 to May 15, 1986	Seven-day sample from all hospitals with active OB units; military hospitals excluded	Thirty participating hospitals reflecting a cooperation rate of 97%	N=331, yielding a participation rate of 83%		Data entry, verification and analysis performed by MSPHD

TABLE 1
(Continued)

Summary of S. ..cy Implementation

State	Purpose	Survey Instrument	Key Organizational Support	Time Frame	Sample	Hospital Participation	Patient Participation	Representativeness	Data Entry and analysis
New York	Provide enrollment targets for Prenatal Care and Nutrition Program	32 items, including non-core questions on history of insurance coverage, participation in other MCH programs, barriers to care, eating and smoking behavior	Support from the Health Commissioner, Governor's Conference, and the Hospital Association of New York State	March 16, 1987 to April 13, 1987	Excluded the five boroughs of NYC; seven-day sample of all upstate hospitals with active OB units				Performed by NYS Department of Health, Division of Family Health, Planning Development and Evaluation Unit; flat file of new data provided to MSPWD on milled floppy disk.
Oklahoma	Provide data on why some women access care in third trimester; construct database for program planning and for preparing MCH block grant proposal	Lengthy 37 item, 11 page instrument; included items on social support, pregnancy intention, opinions on importance of care and health status, perceptions of barriers to care	Support from Perinatal Task Force, Governor's Conference on Infant Mortality, State Hospital Association, Oklahoma State University	June 26, 1986 to July 21, 1986	Excluded participation of military hospitals; seven-day sample of births from all hospitals with OB units	N=93, reflecting 98% hospital cooperation	N=797, a 92% patient participation rate	No sample-population differences on maternal age, race, and education; differences on tri-mester care began and number of prenatal visits	Performed by Oklahoma State Department of Health; flat file of raw data provided to MSPWD on milled floppy disk

TABLE 1
(Continued)

Summary of Survey Implementation

State	Purpose	Survey Instrument	Key Organizational Support	Time Frame	Sample	Hospital Participation	Patient Participation	Representativeness	Data Entry and Analysis
Oregon	Provide information correlating income with adequacy of care; for use in legislative lobbying activity; for use in preparing MCH block grant application	Combined survey and birth certificate data collection; an eight item questionnaire was attached to birth certificates	Major support from office of vital statistics; Hospital association sent letter of support 2 weeks following beginning of data collection period	June 23, 1985 to July 6, 1986	Fourteen-day sample with all hospitals with 22 births per month in 1985. Included survey mailings to women delivering outside of the hospital setting.	Thirty-six hospitals submitted matched surveys and birth certificates, reflecting 95% cooperation	N=1,042, reflecting 79% patient participation	No population-sample differences on low birthweight, marital status, and multiple births; mothers with less than 12 years of education and <18 years of age were less likely to respond to the survey	Performed by statistician from the MCH Program, Office of Health Services, Oregon Dept. of Human Resources. Computer tape provided to MSPHD
Rhode Island	Provide information for lobbying state legislature to expand Medicaid coverage, and coverage for the uninsured; collect data about care patterns of Hispanic and Southeast Asian women	31 item survey included items on smoking, diet, transportation, reasons for missed appointments, and importance of prenatal care. Included face sheet documenting characteristics of non-respondents. Spanish and Portuguese translations.	No hospital association involvement	July 30, 1986 to Sept. 10, 1986	Seven-day sample with seven of eight hospitals; two week sample with large hospital in Providence	All eight MCH hospitals participated (100%)	N=537, a patient response rate of 94%	No differences on maternal age, marital status, trimester care began, and number of prenatal visits; sample more likely to be less educated	Performed by Rhode Island Division of Family Health, and a graduate research assistant from Yale University. Floppy disk with raw data file submitted to MSPHD

TABLE 1
(Continued)

Summary of Survey Implementation

State	Purpose	Survey Instrument	Key Organizational Support	Time Frame	Sample	Hospital Participation	Patient Participation	Representativeness	Data Entry and Analysis
South Carolina	Assess need for Low Birthweight Prevention Programs; provide data on barriers to care	Lengthy 45 item instrument designed at eighth grade reading level; includes items on general health status, social support, reasons for seeking and stopping care, the importance of care, and barriers to care	Personal endorsement of Governor to hospital administrators, Hospital Association, the Commissioner of Health	August 15, 1966 to October 31, 1965	Stratified quota sample with initial goal of 1500 postpartum women	N=33, reflecting a 91% rate of participation	N=1,121, reflecting patient response rate of 81%		Performed by Division of Maternal and Child Health, South Carolina Dept. of Health and Environmental Control. Computer tape provided to MSPRD.
Texas	Assess need for MCHIA Program (Maternal and Child Health Improvement Act); expand Medicaid coverage	34 item instrument including items concerning reasons for stopping and seeking care, importance of prenatal care, pregnancy intention, payment for delivery, postpartum and well-child care plans, and medical complications of pregnancy	Hospital association sent letter of support to hospital administrators	October 27, 1966 to January 30, 1967	Three tier stratified seven-day sampling based on number of annual births per hospital, included a certainty stratum for the largest hospitals	N=116, reflecting a participation rate of 71%	N=2,032, reflecting a 70% patient response	Good sample-population match on maternal race, maternal age, marital status, trimester prenatal care began, and low birthweight	Performed by Public Policy Resource Laboratory, Texas A & M University. Data sent over telephone to MSPRD.

MSPND NEED ESTIMATES

The following tables present estimates of unmet need for prenatal care for the 10 states involved in the Multi-State Prenatal Needs Determination project (MSPND). The data was collected through surveys with a sample of postpartum women in each state. Although, in general, survey response rates were high, and the demographic and health service profiles of women in the sample closely matched the population of all women giving birth (indicating good representativeness), the small differences that were observed suggested a conservative bias in the unmet need estimates. Therefore, the estimates reported here should be considered the lower bound of the actual level of unmet need.

The estimates are based on the following definition of need: proportion of women giving birth in a year whose household income is below a specified poverty level, and who do not possess third party coverage, that is, private health insurance or Medicaid. Seven poverty levels are included in the tables for each state so that alternative program eligibility criteria can be examined by policy makers. The 1986 household income guidelines for different family sizes were employed across the 10 states in computing poverty status. Total percents for the "No third party" group at each of the seven alternative poverty levels were applied to 1986 births to produce estimates of the number of annual births meeting the definition of unmet need for each state. Proportion of births and number of births are presented separately for each poverty level group, as well as cumulatively.

Percent of Poverty

Family Size	50%	75%	100%	125%	185%	200%
1	2,680	4,020	5,360	6,700	9,916	10,720
2	3,620	5,430	7,240	9,050	13,394	14,480
3	4,560	6,840	9,120	11,400	16,872	18,240
4	5,500	8,250	11,000	13,750	20,350	22,000
5	6,440	9,660	12,880	16,100	23,828	25,760
6	7,380	11,070	14,760	18,450	27,306	29,520
7	8,320	12,480	16,640	20,800	30,784	33,280
8	9,260	13,890	18,520	23,150	34,262	37,040
9	10,200	15,300	20,400	25,500	37,740	40,800
10	11,140	16,710	22,280	27,850	41,218	44,560
11	12,080	18,120	24,160	30,200	44,696	48,320
12	13,020	19,530	26,040	32,550	48,174	52,080
13	13,960	20,940	27,920	34,900	51,652	55,840
14	14,900	22,350	29,800	37,250	55,130	59,600
15	15,840	23,760	31,680	39,600	58,608	63,360
16	16,780	25,170	33,560	41,950	62,086	67,120
17	17,720	26,580	35,440	44,300	65,564	70,880
18	18,660	27,990	37,320	46,650	69,042	74,640
19	19,600	29,400	39,200	49,000	72,520	78,400
20	20,540	30,810	41,080	51,350	75,998	82,160
21	21,480	32,220	42,960	53,700	79,476	85,920
22	22,420	33,630	44,840	56,050	82,954	89,680

State	Time Frame	Hospital Participation	N	Patient Participation	N
AZ	June 1986	91%	51	82%	892
CA	January 1987	93%	282	81%	2026
MI	January 1986	95%	124	84%	1892
NM	April 1986	97%	30	83%	331
NY	March 1987	97%	134	74%	2031
OK	June 1986	98%	93	92%	797
OR	June 1986	95%	36	79%	1042
RI	July 1986	100%	8	94%	537
SC	August 1986	91%	53	81%	1082
TX	October 1986	74%	116	70%	2032

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Women with no Third Party Source of Payment
for Prenatal Care

by Poverty Level*

Arizona

Poverty Level	Percent of Total		Number of Births**	
	%	cum.%	freq.	cum.freq.
< 50 %	8.15	3.15	4,963	4,963
50 - 74.9%	4.15	12.30	2,527	7,489
75 - 99.9%	2.88	15.18	1,754	9,243
100 - 124.9%	3.51	18.69	2,137	11,380
125 - 184.9%	4.15	22.84	2,527	13,907
185 - 199.9%	1.44	24.28	877	14,784
> 200 %	7.03	31.31	4,281	19,065
	31.31		19,065	

* These figures do not include women with Medicaid benefits or those with some form of insurance that provides for maternity benefits including prenatal care.

** Based on 60,890 1986 Arizona births.

Women with no Third Party Source of Payment
for Prenatal Care

by Poverty Level*

California

Poverty Level	Percent of Total		Number of Births**	
	%	cum.%	freq.	cum.freq.
< 50 %	4.30	4.30	20,589	20,589
50 - 74.9	3.48	7.78	16,663	37,252
75 - 99.9	3.34	11.12	15,993	53,245
100 - 124.9	2.37	13.49	11,348	64,593
125 - 184.9	4.74	18.23	22,696	87,289
185 - 199.9	0.74	18.97	3,543	90,833
> 200	14.08	33.05	67,418	158,251
	33.05		158,251	

* These figures do not include women with Medicaid benefits or those with some form of insurance that provides for maternity benefits including prenatal care.

** Based on 478,822 1986 California births.

Women with no Third Party Source of Payment
for Prenatal Care

by Poverty Level*

Michigan

Poverty Level	Percent of Total		Number of Births**	
	%	cum.%	freq.	cum.freq.
<50%	0.79	0.79	1,076	1,076
50 - 74.9	0.71	1.50	967	2,043
75 - 99.9	0.95	2.45	1,294	3,337
100 - 124.9	1.90	4.35	2,588	5,925
125 - 184.9	2.85	7.20	3,882	9,806
185 - 199.9	0.32	7.52	436	10,242
>200	5.14	12.66	7,001	17,243
	12.66		17,243	

* These figures do not include women with Medicaid benefits or those with some form of insurance that provides for maternity benefits including prenatal care.

** Based on 136,198 1986 Michigan births.

Women with no Third Party Source of Payment
for Prenatal Care

by Poverty Level*

New Mexico

Poverty Level	Percent of Total		Number of Births**	
	%	cum.%	freq.	cum.freq.
< 50 %	5.53	5.53	1,325	1,325
50 - 74.9	5.14	10.67	1,231	2,556
75 - 99.9	7.51	18.18	1,799	4,354
100 - 124.9	4.74	22.92	1,135	5,490
125 - 184.9	6.72	29.64	1,610	7,099
185 - 199.9	2.37	32.01	568	7,667
> 200	8.30	40.31	1,988	9,655
	40.31		9,655	

* These figures do not include women with Medicaid benefits or those with some form of insurance that provides for maternity benefits including prenatal care.

** Based on 23,952 1986 New Mexico births.

Women with no Third Party Source of Payment
for Prenatal Care

by Poverty Level*

New York

Poverty Level	Percent of Total		Number of Births**	
	%	cum.%	freq.	cum.freq.
< 50 %	2.56	2.56	6,780	6,780
50 - 74.9	0.31	2.87	821	7,601
75 - 99.9	0.36	3.23	953	8,554
100 - 124.9	2.31	5.54	6,118	14,672
125 - 184.9	1.33	6.87	3,522	18,195
185 - 199.9	0.46	7.33	1,218	19,413
> 200	3.69	11.02	9,773	29,186
	11.02		29,186	

* These figures do not include women with Medicaid benefits or those with some form of insurance that provides for maternity benefits including prenatal care.

** Based on 264,844 1986 New York Births.

Women with no Third Party Source of Payment
for Prenatal Care

by Poverty Level*

Oklahoma

Poverty Level	Percent of Total		Number of Births**	
	%	cum.%	freq.	cum.freq.
< 50 %	5.18	5.18	2,490	2,490
50 - 74.9	3.36	8.54	1,615	4,104
75 - 99.9	3.36	11.9	1,615	5,719
100 - 124.9	4.62	16.52	2,220	7,940
125 - 184.9	5.74	22.26	2,759	10,698
185 - 199.9	0.70	22.96	336	11,035
> 200	21.85	44.81	10,501	21,536
	44.81		21,536	

* These figures do not include women with Medicaid benefits or those with some form of insurance that provides for maternity benefits including prenatal care.

** Based on 48,061 1986 Oklahoma Births.

Women with no Third Party Source of Payment
for Prenatal Care

by Poverty Level*

Oregon

Poverty Level	Percent of Total		Number of Births**	
	%	cum.%	freq.	cum.freq.
< 50 %	1.80	1.80	726	726
50 - 74.9	3.83	5.63	1,546	2,272
75 - 99.9	3.72	9.35	1,501	3,773
100 - 124.9	3.04	12.39	1,227	5,000
125 - 184.9	4.95	17.34	1,998	6,998
185 - 199.9	0.90	18.24	363	7,361
> 200	2.25	20.49	908	8,269
	20.49		8,269	

* These figures do not include women with Medicaid benefits or those with some form of insurance that provides for maternity benefits including prenatal care.

** Based on 40,356 1986 Oregon Births.

Women with no Third Party Source of Payment
for Prenatal Care

by Poverty Level*

Rhode Island

Poverty Level	Percent of Total		Number of Births**	
	%	cum.%	freq.	cum.freq.
< 50 %	0.59	0.59	82	82
50 - 74.9	0.39	0.98	54	137
75 - 99.9	0.59	1.57	82	219
100 - 124.9	0.20	1.77	28	247
125 - 184.9	2.73	4.50	380	627
185 - 199.9	0.01	4.51	1	628
> 200	3.91	8.42	545	1,173
	8.42		1,173	

* These figures do not include women with Medicaid benefits or those with some form of insurance that provides for maternity benefits including prenatal care.

** Based on 13,935 1986 Rhode Island births.

Women with no Third Party Source of Payment
for Prenatal Care

by Poverty Level*

South Carolina

Poverty Level	Percent of Total		Number of Births**	
	%	cum.%	freq.	cum.freq.
< 50 %	1.74	1.74	863	863
50 - 74.9	2.91	4.65	1,443	2,307
75 - 99.9	5.81	10.46	2,882	5,189
100 - 124.9	3.78	14.24	1,875	7,064
125 - 184.9	6.40	20.64	3,175	10,238
185 - 199.9	0.58	21.22	288	10,526
> 200	4.65	25.87	2,307	12,833
	25.87		12,833	

* These figures do not include women with Medicaid benefits or those with some form of insurance that provides for maternity benefits including prenatal care.

** Based on 49,604 1986 South Carolina births.

Women with no Third Party Source of Payment
for Prenatal Care

by Poverty Level*

Texas

Poverty Level	Percent of Total		Number of Births**	
	%	cum.%	freq.	cum.freq.
< 50 %	9.3	9.3	29,273	29,273
50 - 74.9	5.5	14.8	17,311	46,584
75 - 99.9	3.4	18.2	10,702	57,286
100 - 124.9	1.9	20.1	5,981	63.267
125 - 184.9	3.6	23.7	11,331	74,598
185 - 199.9	0.6	24.3	1,889	76,487
> 200	6.6	30.9	20,774	97,261
	30.9		97,261	

* These figures do not include women with Medicaid benefits or those with some form of insurance that provides for maternity benefits including prenatal care.

** Based on 314,760 1986 Texas Births.

APPENDIX A

THE CORE QUESTIONS

1. Who was your main care provider during your pregnancy? (check one)

___1. private family physician
___2. private OB/GYN physician
___3. publicly-funded or low cost OB clinic in hospital
___4. publicly-funded or low cost OB clinic outside of hospital
___5. certified nurse-midwife
___6. other
___7. I didn't receive prenatal care

2. During what month of your current pregnancy did you begin prenatal care?

___ month (fill in number from 1st month to 9th month)
___ I did not receive prenatal care

3. How many prenatal care visits did you have during your pregnancy?

___ visits (give number of prenatal visits you had with your provider for this pregnancy)
___ I did not receive prenatal care (that is I had no or zero prenatal visits for this pregnancy)

4. How many grades of school have you completed?

Give the last grade number you completed
___ years of education (e.g., completion of eighth grade equals eight, high school or GED equals 12; two years of college equals 14 years of education)

5. What is your marital status?

___1. never married
___2. married
___3. widow
4. ___ divorced
5. ___ separated

6. What was the main source of payment for the prenatal care you received during this pregnancy?

___1. Health insurance
___2. Health Maintenance Organization (prepaid Group Practice)
___3. Medicaid
___4. Personal Income or Savings
___5. Free or low cost public clinic
___6. Loan
___7. Unable to pay
___8. Other_____
(specify)

7. During your pregnancy, was the major income earner in your household employed?

____ yes ____ no

8. How difficult was it for you to pay for the prenatal care you received during your pregnancy? (check one)

___1. impossible
___2. very difficult
___3. difficult
___4. somewhat difficult
___5. not difficult

9. How many miles did you travel on each visit to receive prenatal care during your pregnancy?

_____ miles
(give number)

10. Name the county you live in.

_____

11. Give the City, Village and township of your residence (not street address)

_____
_____
Zip Code _____

12. Your Birthdate: _____/_____/_____
month day year

13. What is your race?

___(1) Black
___(2) White
___(3) Other _____
(specify)

14. Are you Hispanic?

_____ yes _____ no

15. Total family income for the last 12 months before deductions (in dollars).

$_____

16. Does this income include any public assistance, food stamps or unemployment compensation?

_____ (1) yes _____ (2) no

17. How many people are in your family, that is, the number supported by this income?

__ __

Mr. WEISS. Thank you very much, Dr. Johnson.
Ms. Brown.

STATEMENT OF SARAH BROWN, STUDY DIRECTOR, COMMITTEE ON PRENATAL CARE, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES

Ms. BROWN. Good morning.

I am very pleased to be asked to talk with the subcommittee today about access to prenatal care in the United States. The points I wish to make derive from two activities conducted by the Institute of Medicine: a report published in 1985 on preventing low birthweight, and a project now nearing completion on outreach for prenatal care.

Underlying the hearing this morning, of course, is the fact that in 1985 approximately one-fourth of all babies born in the United States were to women who failed to begin prenatal care early in pregnancy, and over 5 percent were to mothers who received little or no care at all. For certain subgroups, the rates are far worse, and moreover in 1985 for the sixth consecutive year there was no progress in reducing the percent of infants born to women who receive late or no care. For blacks the size of this group actually appears to be increasing.

Now, why are the rates of inadequate prenatal care troubling? It is an important question to ask, I think. First, the consensus is broad and deep that prenatal care works. It is an effective intervention that is strongly and clearly associated with improved pregnancy outcomes. Moreover, its benefits seem greatest for those most at risk.

Second, the importance of prenatal care is heightened by evidence of its cost effectiveness, which has been mentioned a number of times this morning.

Third, rates of maternal mortality, low birthweight and infant mortality are notably lower in many other countries than in the United States, a difference that is due in part to the better participation in prenatal care evident in these other nations.

The Institute has defined several barriers to more complete participation in prenatal care in the United States and has outlined a number of suggestions for how these barriers could be overcome. At the heart of our many suggestions is the conclusion that full access to this important service requires a fundamental assumption of responsibility by the public sector for making such services available.

Now, in the last few years at least a portion of our recommended plan of action has been put into place, although I don't mean to suggest that our reports have been the sole stimulus. In particular, a large number of States, over half the States I think, and many communities have acted to increase early registration in prenatal care. You are going to be hearing this morning about the healthy start initiative in Massachusetts. Other well-known initiatives are ones in Michigan, California, Texas, New York, and Florida.

The energy level and volume of new programs exhibited by the States have not been matched at the Federal level. Congressional action on prenatal care access has been limited to the partial pro-

tection accorded the Maternal and Child Health Services block grant, particularly the supplemental funding in fiscal year 1987.

Other important congressional action has been the passage of the maternal and infant care amendments in the 1986 Omnibus Budget Reconciliation Act which, among other things, provide States the greatest opportunity to date to sever the link between Medicaid and the welfare system.

Executive branch action on access to prenatal care has been even smaller in scope, although one important initiative has been the convening of the U.S. Public Health Service expert panel on the content of prenatal care.

One general recommendation we have made that has not been embraced by either the Federal Government or the States is the need for dramatic simplification of the Medicaid program. I find it too confusing to understand myself. I don't understand how women and providers understand it at all.

As alluded to earlier, the Institute initiated a study about 15 months ago on how to draw pregnant women into prenatal care. We will soon issue a final report. And I want to end my statement with a couple of observations growing from this present study.

First, we are finding that understanding the antecedents of poor prenatal care use is greatly aided by data from surveys of women who have experienced difficulty in securing timely care. The GAO survey just presented is a case in point. We have located over 20 such surveys, although they are of greatly varying quality and analytic sophistication. In our report, we will be presenting a sort of "meta-analysis" of their findings.

In a particularly interesting study released within the past week, Dr. Gary Richwald and a team of researchers at the UCLA School of Public Health reported the results of a survey of the 251 women delivering during an 18-week period at LA County/USC Women's Hospital, having had no prenatal care at all. Of the primary reasons reported by these women for their complete absence of care, 46 percent were economic, 33 percent were organizational, particularly difficulty in securing an appointment, and 17 percent were attitudinal, such as "thought prenatal care was unnecessary."

The investigators compiled extensive materials on financial and institutional barriers to care which I recommend you review. Their data show clearly that particularly for this very high risk group, the maternity system is not operating in a way that eases entry into needed care. The barriers to care in this study and in many others are clearly based in the health care system and not in women's attitudes or knowledge.

Over the last year, we have been informally reviewing problems of access around the country, such as those addressed this morning, and the myriad approaches being tried to increase early registration and care. Just as there are many barriers to care, so also are there many strategies to reduce them.

We have classified remedial programs into six groups: First, those that emphasize removal of financial barriers; second, those that accomplish basic increases in system capacity; third, those directed mainly at significant institutional reform; fourth, ones focused on active case finding and recruitment through such activities as street canvassing and telephone surveys; fifth, programs

that offer intensive social supports and counseling; sixth and finally, provision of incentives through a wide variety of mechanisms, including cash payments. At present, available data are being assembled and analyzed on about 30 programs that fit these categories.

The complexity of the access problem no doubt means that in any given community some or all of these approaches may be required. Our committee will be commenting on the relative importance and impact of each of these strategies and on a series of related issues.

Let me conclude by saying that overall we are more impressed with the impact of programs that remove financing and institutional barriers, for example, than those that employ traditional outreach activities to ease access. Although it may be cheaper, easier and more glamorous to employ outreach workers or mount a community education campaign, the major barriers appear to be systemic and require changes at that level.

Thank you.

[The prepared statement of Ms. Brown follows:]

Testimony of

Sarah S. Brown
Study Director
Institute of Medicine
National Academy of Sciences

Before the Subcommittee on Human Resources
and Intergovernmental Relations
Committee on Government Operations
U.S. House of Representatives

Wednesday
September 30, 1987

Good Morning. I am very pleased to be asked to talk with the Subcommittee on Human Resources and Intergovernmental Relations about access to prenatal care in the U.S. The points I wish to make derive from two activities conducted by the Institute of Medicine/National Academy of Sciences--a report published in 1985 on preventing low birthweight, and a project now nearing completion on outreach for prenatal care which examines how best to draw women into prenatal care early in pregnancy. I have served as the study director of both efforts, funded by a combination of support from private foundations, voluntary groups, and the U.S. Public Health Service.

Underlying the hearing this morning is the fact that in 1985, approximately one fourth of all babies born in the U.S. were to women who failed to begin prenatal care early in pregnancy and over five percent were to mothers who received little or no care at all. For certain subgroups, the rates are far worse. For example, of babies born to black teenagers, only 47 percent were to mothers who began care in the first trimester, and 14 percent were to mothers who had little or no care at all. Moreover, recent trends in use of prenatal care are not improving for all groups. In 1985, for the sixth consecutive year, there was no progress in reducing the percent of infants born to women who received late or no care. For blacks, the size of this group actually appears to be increasing. National Center for Health Statistics natality data show that in 1980, 8.8 percent of black infants were born to mothers having had seriously inadequate prenatal care; by 1985, this number had grown to 10.3 percent.

Why are these rates of inadequate prenatal care use troubling? It's an important question to ask, I think, because prevention-oriented care is often poorly valued. Inadequate participation in prenatal care and the disturbing recent trends are important challenges to public policy and to the health care system for several reasons. First, the consensus is broad and deep that prenatal care is an effective preven- tive intervention that is strongly and clearly associated with improved pregnancy outcomes. Declines in rates of both infant mortality and its common antecedent, low birthweight, have been repeatedly linked to full participation in high quality prenatal care offering a wide variety of services and social supports, well connected to hospital-based services such as neonatal care. Moreover, the benefits of prenatal supervision seem greatest for those most at risk, whether because of social conditions, health burdens or both. Although the methodological difficulties of proving incontrovertibly that prenatal care is efficacious are substantial (and, in some sense, insurmountable because randomized clinical trials are precluded for ethical and other reasons), exhaustive reviews of the literature and recent analyses continue to underscore the value of this basic health service.

Second, the importance of prenatal care is heightened by evidence of its cost effectiveness, particularly for low income women who obtain relatively inadequate prenatal care and who are at increased risk of a poor pregnancy outcome. For example, in 1985, the Institute of Medicine calculated that over $3 could be saved in one year in direct medical care expenditures for low birthweight infants for each dollar invested in prenatal care in a particularly high-risk target group.

Third, comparisons of the U.S. with many other countries, both those highly developed and those less so, bring into sharp relief the discouraging picture of U.S. pregnancy-related care. Rates of maternal mortality, low birthweight and infant mortality are notably lower in many other countries than in the U.S., a difference due in part to the better participation in prenatal care evident in these countries. As elaborated recently by Dr. C. Arden Miller, chairman of the Department of Maternal and Child Health at the University of North Carolina, it is apparent that many other countries approach the provision of care to pregnant women as a form of social investment. Prenatal care, like health services generally, is made readily available with minimal barriers or preconditions in place. Such services are seen as part of a broad social strategy to protect and support childbearing and to produce healthy future generations.

The Institute of Medicine, like other organizations and individuals testifying today, has inquired carefully into the conditions that act as barriers to more complete participation in prenatal care in the U.S. The profoundly different approach to providing health services demonstrated by countries with better rates of prenatal care use has already been noted. These different philosophical underpinnings undoubtedly lie at the base of the obstacles to prenatal care commonly recognized in the U.S.:

- o financial constraints, including inadequate insurance—both public and private—to purchase adequate prenatal care;
- o inadequate availability of maternity care providers, particularly providers willing to serve socially disadvantaged or high-risk pregnant women;
- o insufficient prenatal services in some sites routinely used by high-risk populations such as Community Health Centers, hospital outpatient clinics, and health departments;
- o experiences, attitudes, and beliefs among women that make them disinclined to seek prenatal care;
- o transportation and child care services that are poor or absent; and
- o inadequate systems to recruit hard-to-reach women into care.

The Institute has outlined a variety of initiatives to lessen each of these obstacles. It has been our overriding conclusion, however, that problems of access reflect primarily the nation's patchwork, nonsystematic approach to making such services available. Although numerous programs have been developed in past years to extend prenatal care to more women, no institution bears responsibility for assuring that such services are genuinely available in some very fundamental, practical sense. That is, no local, state, or federal entity can be held accountable for inadequate care. Without such responsibility or accountability, it should not be

surprising that gaps in care remain and that efforts to expand prenatal services often face enormous organizational and administrative difficulties.

The federal government has long been on record as supporting prenatal care and urging that all women secure such care early in pregnancy. This support, however, must be accompanied by specific, tangible actions:

- o providing funds to state and local agencies in amounts sufficient to remove financial barriers to prenatal care (through channels such as the Maternal and Child Health Services Block Grant, Medicaid, health departments, Community Health Centers, and related systems);
- o providing prompt, high-quality technical consultation to the states on clinical, administrative, and organizational problems that can impede the extension of prenatal services;
- o defining a model of prenatal services for use in public facilities providing maternity care; and
- o funding demonstration and evaluation programs, and supporting training and research related to these responsibilities.

We have urged further that states take a complementary leadership role in extending prenatal services, backed by adequate federal money, support, and consultation. One way to do so is for each state to designate an organization--probably the state health department--as responsible for ensuring that prenatal services are reasonably available and accessible in every community. This would involve the state in:

- o assessing unmet needs--e.g., surveying existing prenatal services and identifying the localities and populations that have inadequate prenatal services;
- o serving as a broker to contract with private providers to fill gaps in services; and
- o in some instances, providing prenatal services directly through facilities such as Community Health Centers and health department clinics.

In addition, we have suggested that in each community, a single organization be designated by the state as the "residual guarantor" of prenatal services. These organizations should be provided with sufficient funds to care for pregnant women who still remain outside of the prenatal care system. Local health departments could meet this responsibility in many ways: through contracts with private providers; through special programs; through arrangements with local hospitals, medical schools, and nurse-midwifery services; and through direct provision of care.

We also have urged that a public-private task force be convened under the auspices of the Secretary of the Department of Health and Human Services to define the specifics of a system for making prenatal care genuinely available to all pregnant women in the United States.

At the heart of our suggestions is the conclusion that full access to prenatal care requires a fundamental assumption of responsibility by the public sector for making such services available. In many instances, arrangements with private providers will be able to fill gaps in care; in others, governmental agencies may need to provide care directly. Federal leadership will be critical to this policy goal, but states also must attach high priority to prenatal care. At both levels, full support of the private sector and a greater commitment of public funds will be required.

In the last few years, at least a portion of our recommended plan of action has been put into place, although I don't mean to suggest that our reports have been the sole stimulus. In particular, a large number of states and communities have acted to increase early registration in prenatal care. Some activities are organized around the goal of reducing infant mortality; some are directed at preventing low birthweight; others are addressed to the full range of family planning, prenatal, delivery, postpartum and pediatric services. Common to them all is a clear goal of removing obstacles to full participation in prenatal care. You are hearing this morning about the Healthy Start initiative in Massachusetts. Other well known initiatives include:

- o the Prenatal Care and Nutrition Program of New York State
- o the "9 by 90" Campaign in Illinois
- o the Michigan initiative to include prenatal and postpartum maternity care as a "basic health service"
- o the expansion of the "OB Access" pilot program in 13 California counties to the full state
- o the expanded Improved Pregnancy Outcome project of Florida

As part of our current study, we are reviewing available data from these programs and many others to determine their impact on access to prenatal care.

The energy level and volume of new programs exhibited by the states have not been matched at the federal level. Congressional action on prenatal care access has been limited to the partial protection accorded the Maternal and Child Health Services Block Grant, particularly the supplemental appropriations in FY 87 that increased the block grant's funding from its static level of $479 million for several years to $496 million. I believe the FY '88 budget will include an additional increase as well. Other important Congressional action has been the passage of the Maternal and Infant Care amendments in the 1986 Omnibus Budget Reconcili-

ation Act which, among other things, provide states the greatest opportunity to date to sever the link between Medicaid and the welfare system.

Executive Branch action on access to prenatal care has been even smaller in scope, although one important initiative has been the convening of the U.S. Public Health Service Expert Panel on the Content of Prenatal Care. Organized at the initiative of the Public Health Service's Task Force on Low Birthweight, this gro 's mandate is broad and significant. Among other activities, it is proposing a list of outcome measures by which the value of prenatal care should be judged. The list suggests that the worth of prenatal services should not rest solely on its effect on either infant mortality or birthweight—a focus which has dominated recent discussions of prenatal c e—but should instead consider a much broader array of measures, including, for example, family functioning, planning of future pregnancies, child abuse and neglect, and maternal stress.

In response to the continuing seriousness of poor use of prenatal care, the Institute initiated a study about 15 months ago on how to draw pregnant women into prenatal care; as I mentioned, we will soon issue a final report. Although I obviously am constrained from presenting our emerging conclusions and recommendations, I did want to end my statement with two observations growing from this present study.

First, we are finding that understanding the antecedents of poor prenatal care use is greatly aided by data from surveys of women who have experienced difficulty in securing timely prenatal care. The General Accounting Office survey presented this morning is a case in point. We have located about 25 such surveys (of greatly varying quality and analytic sophistication) and will be presenting a sort of "meta-analysis" of their findings.

Data from Lea County, New Mexico and from Los Angeles merit mention. A grant from the Robert Wood Johnson Foundation underlay a major effort in Lea County in the early 1980s to reduce the county's infant mortality rate. The community reported one of the highest per capita incomes in the state, but had an infant death rate of 19.8 per 1,000 live births, 80 percent higher than the state average and among the highest county rates in the nation. To determine why women were not receiving prenatal care, a survey was initiated at the request of several community physicians who felt that financial barriers to care were probably not very important but that factors such as cultural practices and lack of information were decisive. Ninety-two women were interviewed who had been "walk-ins" in Lea County during the previous five years, meaning that they had arrived at the area's only hospital in labor, having had little or no prenatal care. Contrary to what the physicians expected, 77 percent of these "walk-in women" stated that the reason they had not received adequate prenatal services was that they could not afford it. The enormous difference between the views of the physicians and of the women was clearly revealed by the survey, thus easing remedial action.

Similarly, within this past week, Dr. Gary Richwald and a team of researchers at the UCLA School of Public Health reported the results of a survey of the 251 women delivering during an 18-week period (in 1987) at Los Angeles County/USC Women's Hospital having had no prenatal care at all. Of the primary reasons reported by these women for their complete absence of prenatal services, 46 percent were economic (mainly inability to pay for care), 33 percent were organizational (particularly difficulty scheduling an appointment), and 17 percent were attitudinal (such as "thought prenatal care was unnecessary"). The investigators compiled extensive materials on financial and institutional barriers to care which I recommend you review. Their data show clearly that, particularly for this very high-risk group, the maternity system is not operating in a way that eases entry into needed care. The barriers to care in this study and in that of Lea County are clearly based in the health care system, not in women's attitudes or knowledge.

Over the last year, we have been informally reviewing problems of access around the country, such as those addressed in the surveys just summarized, and the myriad approaches being tried to increase early enrollment in prenatal care. Just as there are many barriers to care, so also are there many strategies to reduce the barriers. We have classified them into six groups:

- removal of financial barriers to care (often through state-wide initiatives);
- basic increases in system capacity (such as adding new clinics or bringing more maternity care providers into an underserved community);
- significant institutional reform such that prenatal services become more genuinely accessible to pregnant women. These approaches attend to such nitty-gritty issues as ease of the Medicaid application process, waiting times for appointments, respect accorded clients, and general clinic ambiance;
- active case-finding and recruitment through such activities as street canvassing, telephone surveys, cross-program referrals (as between WIC and prenatal programs), hotlines and media-based efforts such as TV spots describing a particular prenatal care program;
- intensive social supports, counselling and linkages to other needed services (home visiting is perhaps the best example of such an approach, often conducted in nonclinical settings). These efforts are often directed more to keeping women in care than to case-finding; and
- provision of incentives through a wide variety of mechanisms including cash payments and free distribution of baby items, maternity clothes, transportation tokens, and other items.

We are studying two or more programs emphasizing each of these approaches. At present, available data are being assembled and analyzed on about 30 programs that fit these categories.

The complexity of the access problem no doubt means that in any given community, some or all of these approaches will be required. Our committee will be commenting on the relative importance and impact of each of these strategies and on a series of related issues. We hope to have an opportunity to present such findings to this committee and others after publication.

Thank you.

Mr. WEISS. Thank you very much, Ms. Brown. We look forward to that report.

Dr. Havas.

STATEMENT OF STEPHEN HAVAS, M.D., ACTING COMMISSIONER, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, ACCOMPANIED BY CATHERINE HESS, DIRECTOR, POLICY OFFICE, DIVISION OF FAMILY HEALTH SERVICES

Dr. HAVAS. Good morning, Mr. Chairman, Ms. Pelosi, and committee staff members.

My name is Dr. Stephen Havas, and I am the acting commissioner for the Massachusetts Department of Public Health. I am here today with Cathy Hess who is head of the policy office of our division of family health services. And we are here to share with you our State's effort to identify and address barriers to prenatal care.

In recent years Massachusetts has made the reduction of low birthweight and infant mortality a major priority and has invested a large amount of resources toward this end, particularly improved use of prenatal care by low-income and uninsured women. A combination of new, expanded and refocused initiatives has been supported by a mix of State and Federal fundings.

This substantial financial commitment arose from our analysis of statewide birth and death certificate data on prenatal care and infant deaths. In 1981, 83 percent of Massachusetts women who delivered babies received adequate prenatal care as measured by how early and how much care they received. In 1985, this figure had dropped to less than 79 percent.

The rate of infant deaths, which had been declining steadily, rose from 9.6 to 10.1 deaths for every 1,000 births between 1981 and 1982, and then decreased slightly. In 1983, 1984, 1985, it was approximately 9 deaths per 1,000. Particularly alarming, however, was in 1985, that black infant mortality rate jumped substantially by almost 50 percent, and it rose to almost three times the rate for white babies.

At the first indication of these very disturbing trends, the department took a number of steps. One, we convened a task force on prevention of low birthweight and infant mortality to analyze information and recommend strategies for improving the situation. The task force was chaired by former Surgeon General Julius Richmond. At the same time we sought Federal funding to do a survey to find out what the reasons for lack of receiving prenatal care services were and to test a variety of services to address the need.

The Massachusetts prenatal care survey, which was supported by a 3-year grant, has as its primary objective to determine the various factors that were responsible for women receiving inadequate or insufficient care. We did over sample women who had received inadequate care to try and particularly focus in on what the major problems were.

In the one-third of women who received late, little, or no prenatal care, the following problems in order of frequency were identified: no one to care for other children, no health insurance, not enough money to pay for care, being unsure about wanting to be pregnant, fear of doctors and medical procedures, not wanting to

think about being pregnant, having too many other problems to go for care, having no way to get to a care site, not knowing the person was pregnant, and it went on from there. These problems are somewhat similar to those that were found in the GAO report.

The data indicated that these women often encountered multiple problems in obtaining prenatal care. And in fact, on the average had 2.6 problems for those who did receive inadequate care.

The findings from this survey are now being used to design and implement demonstration projects in four target communities and also to implement recommendations from the task force that I alluded to earlier.

The task force presented a comprehensive set of recommendations in five areas with a strong emphasis on improving access to comprehensive prenatal care and overcoming financial barriers to care. The task force noted that there was a need for increased financial assistance to solve some of the problems that had been identified, but also suggested that there were a number of steps the State could take to overcome these problems. And in response, the State did the following things:

One, we amended insurance statutes to eliminate exclusion of maternity benefits; two, Medicaid coverage was expanded; and three, we initiated a new State-funded program called "Healthy Start" to provide maternity coverage for the remaining low-income, uninsured women. To date, that program, which began in December 1985, has enrolled approximately 11,000 women.

This program was designed to promote early and continuous use of comprehensive maternity care. The eligibility requirements were kept simple. Income below 185 percent of the poverty line, and lack of insurance coverage were the main criteria. No resource tests were imposed. There are simple application forms to be filled out either at prenatal care sites or one can do this over a toll-free telephone number. And then once enrolled, women retain their eligibility until 60 days after delivery. We have staff to provide assistance to people in this program and also a lot of community outreach and educational efforts to get people into the program.

In addition, Massachusetts now within the last year has made the Medicaid program available to all pregnant women with incomes below the poverty level. That is an update on the findings that you heard from the GAO finding. And there is no resource test, and eligibility is retained throughout the postpartum period.

We are also currently working to see if we can implement the new presumptive eligibility process.

Evaluation of the Healthy Start program is currently underway, but we already have preliminary evidence of its success: No. 1, the large numbers of women that have enrolled, which I alluded to earlier. We are reaching large numbers of young, single, and minority women. And one in five of the women being enrolled speaks a language other than English.

We have found again from preliminary data that a higher proportion of these women are receiving adequate prenatal care compared to women without such coverage.

There were other recommendations which were made by the task force that I mentioned, to do community-based, culturally sensitive programs. We have been trying to implement those recommenda-

tions in a number of the different projects that we have been funding in the current year. We have a number of innovative kinds of programs, ones that provide a large amount of community support, having people that can speak the languages of the clients being served, improvements in transportation, use of neighborhood homes for doing some of the education and referral services and so forth. Details of that are in the more extensive testimony.

We have also in Massachusetts taken a number of other steps to try and reduce infant mortality and low birthweight. There is an increase in moneys for family planning. State funding for the WIC program has been substantially increased in recent years. And also there are more moneys being put into teen pregnancy prevention. Community coalitions have been funded in 12 different communities to, again, improve infant mortality problems and work on teen pregnancy problems.

Massachusetts has made both a major financial commitment and a moral commitment to dealing with this problem. State funding in fiscal year 1987 approached $30 million, but much more remains to be done. There were many more excellent proposals for maternal and infant care projects than available dollars. Federal MCH support has not kept pace with the need or with inflation. We don't have a means currently for replicating successful demonstration projects because we don't have sufficient funds. And Massachusetts has one of the strongest economies in the Nation. Many other States are in a much worse position than us and don't have the ability to fund the kinds of projects we have been funding.

The Federal Government must join the States to a moral commitment to women and children and provide both leadership and financial resources. The financial barriers to prenatal care clearly must be eliminated. As our survey data also pointed out, women obtaining late and insufficient prenatal care are more likely to be poor, single, and young, have stress-filled lives, fear of medical providers and procedures, unplanned pregnancies and lack of social support.

Intensive community-based outreach, nontraditional educational approaches, personal attention, case management and other forms of support are required before, during and after pregnancy. Resources for the development and maintenance of such innovative strategies are critical. The economic, social and human cost to Government, women and unborn children will continue to mount until women receive the care and support we know they need.

Thank you very much for your attention.

[The prepared statement of Dr. Havas follows:]

REDUCING BARRIERS TO PRENATAL CARE

TESTIMONY TO THE
SUBCOMMITTEE ON HUMAN RESOURCES
HOUSE COMMITTEE ON GOVERNMENT OPERATIONS
SEPTEMBER 30, 1987

Stephen Havas, M.D.
Acting Commissioner
Massachusetts Department
of Public Health

My name is Dr. Stephen Havas and as Acting Commissioner of the Massachusetts Department of Public Health, I am here today to share with you our state's efforts to identify and address barriers to prenatal care.

In recent years, Massachusetts has identified the reduction of low birthweight and infant mortality as a major priority and has invested increased resources toward this end, particularly to improve use of prenatal care by low income and uninsured women. A combination of new, expanded and refocused initiatives has been supported by a mix of state and federal funding.

This substantial public and financial commitment arose from our analysis of statewide birth and death certificate data on prenatal care and infant deaths. In 1981, 83% of Massachusetts women who delivered babies received adequate prenatal care, as measured by how early and how often they received that care. By 1985, this figure had dipped to less than 79%.

The rate of infant deaths, which had been steadily declining, rose from 9.6 to 10.1 infant deaths for every 1,000 live births between 1981 and 1982. While the rate decreased in 1983, we may be reaching a plateau in Massachusetts, as the rate hovered around nine infant deaths for every 1,000 live births in 1983, 1984, and 1985. Particularly alarming, the gap in survival rates between black and white infants widened markedly in 1985. The IMR for black infants increased 46% from 1984 to 1985, standing at almost three times the rate of white babies.

At the first indications of these disturbing trends, the Massachusetts Department of Public Health took several steps to better understand and respond to the problems underlying them. A Task Force on Prevention of Low Birthweight and Infant Mortality was convened to analyze available information and recommend strategies. At the same time, we sought to obtain federal funding to learn directly from pregnant women about their pregnancy and prenatal care experiences, and to test innovative models to address their needs. Both efforts have yielded important results to date, and continue to assist us in refining and building upon current programs.

The Massachusetts Prenatal Care Survey, supported by a three-year federal Maternal and Child Health research and demonstration grant from the Department of Health and Human Services, had as its primary objective the identification of sociodemographic, psychosocial, economic, cultural, and health systems factors associated with prenatal care use. Modeled after the 1980 National Natality Survey, it was a statewide follow-back survey of 2,587 women. The Massachusetts survey included in its sample all women in the state who gave birth in July, August or September of 1985 and had inadequate or no prenatal care during their pregnancy, and a 10% random sample of women residing in other parts of the state who received more adequate care. Additionally, there was oversampling of four communities in the state where the project intended to design and pilot innovative strategies to improve use of prenatal care by high-risk women.

Matching of the survey data with birth certificates indicated that two-thirds of our survey women received adequate prenatal care. The other third, women who received late, little or no prenatal care identified problems that included, in order of magnitude:

- no one to care for other children (19.5%)
- no health insurance (17.1%)
- not enough money to pay for care (16.1%)
- being unsure about wanting to be pregnant (14.6%)
- fear of doctors and medical procedures (13.8%)
- not wanting to think about being pregnant (11.8%)
- having too many other problems to go for care (10.7%)
- having no way to get to care site (9.5%)
- not knowing she was pregnant (9.4%)
- not wanting people to know about the pregnancy (8.7%)
- prenatal care site was too far away (7.9%)
- not being able to get an appointment (7.2%)
- being unable to speak English well (5.3%)
- not knowing where to go for care (5.1%)

The data indicates that women often encounter multiple problems in accessing prenatal care. Women with no prenatal care reported an average of 2.6 problems, while the average for women with adequate care was less than one.

Multivariable statistical analysis demonstrated significant associations between many of these problems and less than adequate prenatal care use. The impact of poverty and lack of insurance coverage as barriers to care was again highlighted. Young age, single marital status, unplanned pregnancies, multiple pregnancies, other problems taking precedence, and not wanting others to know about the pregnancy also emerged as significant factors. Finally, use of a new health care site, use of a hospital clinic, and dissatisfaction with prenatal care were also significantly associated with less than adequate prenatal care use.

The findings from the Massachusetts Prenatal Care Survey are being utilized to design and implement demonstration projects in the project's four target communities, and to guide the implementation of recommendations of the state's Task Force on Prevention of Low Birthweight and Infant Mortality, which is chaired by former U.S. Surgeon General Dr. Julius Richmond.

The Task Force presented a comprehensive set of recommendations in five broad areas, with a strong emphasis on improving access to comprehensive prenatal care. Consistent with the findings of the Massachusetts Prenatal Care Survey, the Task Force cited financial barriers to care for priority attention. The Task Force identified the need for increased federal assistance, but recommended a series of steps that could be taken at the state level if that assistance were not forthcoming.

In response, the state amended insurance statutes to eliminate exclusion of maternity benefits, expanded Medicaid coverage, and initiated a new state funded program to provide maternity coverage for the remaining low-income uninsured women. The Healthy Start Program was launched in December, 1985, and has enrolled over 11,000 women to date.

The Healthy Start Program was designed to promote early and continuous use of comprehensive maternity care. Relieving women of the financial burden of care is a central but not the sole component of the program. Eligibility requirements were kept simple - income below 185% of the federal poverty line and lack of coverage were the main criteria; no resource tests were imposed. Women fill out the simple application form at the prenatal care sites or over the phone on a toll-free line. Once enrolled, women retain their eligibility until 60 days after delivery. Regionally based staff provide assistance in locating prenatal care providers and other health and social services. Posters, brochures, media and community groups are used to let women know about the program.

Some of these features of the Healthy Start program are now being incorporated in Medicaid programs across the country, as a result of new options enacted in the Sixth Omnibus Reconciliation Act, or SOBRA. Massachusetts' Medicaid program is now available to pregnant women with incomes below the poverty level, without a resource test, and eligibility is retained through the postpartum period. Our Department is currently working with Medicaid to implement the new presumptive eligibility process, enabling the state's prenatal care providers to determine Medicaid eligibility on site. We are considering use of the Healthy Start application form for both programs.

Evaluation of the Healthy Start program is underway, and there is preliminary evidence of its success. The sheer number of women enrolled attests to the fact that the program addressed a large unmet need. The program is reaching young, single and minority women in greater numbers than they are represented in the state's births, and one in five participants speaks a language other than English at home. Preliminary analysis of 1986 data from state supported Maternal and Infant Care clinics show that Healthy Start women had higher rates of early and adequate prenatal care use compared to women with no coverage.

The Task Force on Prevention of Low Birthweight and Infant Mortality also made recommendations to address other barriers to care and to promote community based, culturally sensitive programs designed to meet the needs of low income pregnant women. Uninsured women, Medicaid recipients, and other respondents to the prenatal care survey reported lack of social supports and varying levels of stress during pregnancy including financial stress, worry about their housing situations, attempts to get needed services, partner and family concerns, health status during pregnancy, and children, to mention a few. The existence of these stresses suggest the need for improved living conditions for poor or near poor pregnant women. A public health approach supports the need for strategies that include public funding for case management, community and home-based education, and the buttressing of a community's own strengths and resources.

In Massachusetts, in the most recent competitive bidding process for state and federally funded Maternal and Infant Care (MIC) projects, community outreach, health education, psychosocial support and interconceptional care were particularly emphasized. Examples of innovative strategies currently being developed by funded sites include a supportive sister program where community women are trained to work with young parents and serve as positive role models, trained health education counselors who act as teen advocates, and a nurse-midwife who provides prenatal care for pregnant teens in a high school clinic. The same federally funded project that conducted the prenatal care survey has also designed and implemented, in partnership with community agencies, a case management and social support project in rural western Massachusetts. Community volunteers are trained to work with high-risk, poor, and often isolated women by offering advocacy and referral, education, social support, home visits and transportation to care. In the city of Holyoke, the project supports a Spanish-language, culturally relevant drop-in center, where Puerto Rican women can gather to talk with other women and get information and referrals. This same project is currently developing "cases informativas de salud," or health information houses in the neighborhood homes of Puerto Rican women who volunteer their residences as a meeting place for neighbors and friends to talk about pregnancy self-care, to pick up prenatal care health education materials, and to get referrals to services.

Massachusetts has taken many additional steps to reduce low birthweight and infant mortality, including increased state support for family planning, the WIC nutrition program, and teen pregnancy prevention. Community coalitions in twelve communities with the highest rates of teen pregnancy and infant mortality have received state assistance in needs assessment and planning. In FY'87, state funding for public health programs to reduce low birthweight and infant mortality approached $30 million. Massachusetts has made a major financial commitment, and as stated by our House Ways and Means Chairman Richard Voke, a moral commitment to the health of our children. Federal funding through the Maternal and Child Health Services block grant has supported statewide needs assessment and planning, the Maternal and Infant Care Projects, and the survey and demonstration projects I have described today. The state and federal government share equally in the improvements that have been made in the Medicaid program.

But much more remains to be done. There were many more excellent proposals for Maternal and Infant Care Projects than available dollars. Federal MCH support has not kept pace with need or even with inflation. Means for continuing or replicating successful demonstration projects are not at hand. Massachusetts, although enjoying a strong economy, does not have limitless resources. Other states across the country with poorer rates of prenatal care and infant mortality are even more constrained.

The federal government must join the states in a moral commitment to women and children, and provide both leadership and financial resources. The financial barriers to prenatal care clearly must be eliminated. As our survey data also pointed out, women obtaining late and insufficient prenatal care are more likely to be poor, single and young, have stress-filled lives, fear of medical providers and procedures, unplanned pregnancies, and lack of social supports. Intensive community-based outreach, nontraditional educational approaches, personal attention, case management and other forms of support are required before, during and after pregnancy. Resources for the development and maintenance of such innovative strategies are critical. The economic, social and human costs to government, women and unborn children will continue to mount until women receive the care and support we know they need.

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APPENDIX A

ADEQUACY OF PRENATAL CARE UTILIZATION
FOR MASSACHUSETTS RESIDENTS, 1981 THROUGH 1985

Percent with Adequate Prenatal Care

1981	1982	1983	1984	1985
83.0%	82.3%	79.8%	79.7%	78.6%

ADEQUACY OF PRENATAL CARE BY MATERNAL AGE AT DELIVERY
FOR MASSACHUSETTS RESIDENTS, 1981 THROUGH 1985

Age Groups	1981	1982	1983	1984	1985
≤ 19	57.1%	57.6%	54.0%	53.9%	52.7%
20-24	76.9%	75.8%	72.6%	73.1%	71.6%
25-34	86.3%	85.5%	84.2%	85.1%	84.4%
≥ 35	82.4%	83.0%	82.7%	84.1%	84.2%

ADEQUACY OF PRENATAL CARE BY MATERNAL RACE
FOR MASSACHUSETTS RESIDENTS, 1981 THROUGH 1985

Race	1981	1982	1983	1984	1985
White	82.4%	81.8%	80.2%	81.0%	81.3%
Black	65.8%	66.0%	66.4%	68.4%	57.4%
Hispanic	66.4%	63.0%	62.1%	63.6%	58.7%
Asian	67.2%	65.0%	68.8%	72.6%	73.5%

Data Source: Division of Health Statistics and Research, Massachusetts Department of Public Health

Data Analysis: Division of Family Health Services, Massachusetts Department of Public Health

TRIMESTER OF REGISTRATION FOR PRENATAL CARE
FOR MASSACHUSETTS RESIDENTS, 1981 THROUGH 1985

Percent with First Trimester Registration

1981	1982	1983	1984	1985
87.3%	86.4%	84.4%	85.1%	84.3%

TRIMESTER OF REGISTRATION BY MATERNAL AGE AT DELIVERY
FOR MASSACHUSETTS RESIDENTS, 1981 THROUGH 1985

Age Groups	1981	1982	1983	1984	1985
≤ 19	66.1%	65.9%	60.9%	60.7%	60.1%
20-24	84.5%	83.1%	79.2%	79.9%	78.2%
25-34	92.5%	91.4%	89.9%	90.6%	89.6%
≥ 35	89.0%	89.1%	88.4%	89.3%	89.1%

TRIMESTER OF REGISTRATION BY MATERNAL RACE
FOR MASSACHUSETTS RESIDENTS, 1981 THROUGH 1985

Race	1981	1982	1983	1984	1985
White	89.2%	88.2%	86.2%	86.8%	86.6%
Black	75.0%	74.0%	72.3%	73.9%	65.9%
Hispanic	73.2%	70.9%	69.6%	71.8%	69.7%
Asian	75.9%	74.2%	76.1%	78.9%	79.3%

Data Source: Division of Health Statistics and Research, Massachusetts Department of Public Health

Data Analysis: Division of Family Health Services, Massachusetts Department of Public Health

APPENDIX B

MASSACHUSETTS PRENATAL CARE SURVEY
Brief Description

Study Background

- declining prenatal care utilization in Massachusetts
- disparities in adequacy of prenatal care utilization and first trimester registration for prenatal care among age, race, and regional subgroups
- concern over rates due to the association between prenatal care utilization and birth outcome and the mother's health and well-being during pregnancy
- lack of information on barriers to prenatal care, in particular those experienced by high-risk groups, such as teens, minorities, the uninsured, low-income women, Medicaid recipients, and recent immigrants

Study Sponsor

The Massachusetts Prenatal Care Survey (MPCS) is an important component of a three-year, federally funded research and demonstration grant awarded to the Division of Family Health Services, Massachusetts Department of Public Health, in August 1985 by the U.S. Department of Health and Human Services, Division of Maternal and Child Health. The grant supports the MPCS and the planning, implementation, and evaluation of demonstration projects in four areas determined to be at high-risk for inadequate prenatal care utilization and poor birth outcomes: the cities of Boston, New Bedford, and Holyoke, and South Berkshire County in western Massachusetts.

Study Objectives

- to identify behavioral, cultural, socioeconomic, and institutional factors related to prenatal care utilization
- to identify differences and similarities in these factors for age, race, and insurance subgroups of the population
- to collect data useful for planning, implementing, and evaluating projects in four demonstration communities and for policy decisions and program planning in maternal and child health programs in other cities and towns in Massachusetts

Study Content Description

The MPCS, an account from women themselves of their pregnancies, includes information on sociodemographic and socioeconomic characteristics of respondents, self-reported barriers to prenatal care, the characteristics of the prenatal care received, if any, (e.g., waiting time, travel time, satisfaction with care, type of prenatal care site, number of prenatal care sites used, health education received), perceived health status, participation in public programs during pregnancy (e.g., WIC, AFDC, Medicaid), perceived sources and amount of stress during pregnancy, social support, financial accessibility of prenatal care, and many other data items.

Study Design

The design and methodology of the MPCS is that of a "follow-back" survey, modeled on the 1980 National Natality Survey, with participants selected through identification on their infants' birth certificates. The survey was planned and conducted by members of the Prenatal Care Project in the Division of Family Health Services.

The sample for the MPCS was drawn from the 1985 computerized birth file at the Massachusetts Department of Public Health for all women giving birth in Massachusetts between July and September 1985. All women who had inadequate or no prenatal care for this pregnancy were included in the study. Women residing in the four project demonstration communities were oversampled. A 10% random sample of women residing in other areas throughout the state made up the third stratum of the overall sample of 3,087 women.

Confidentiality of the Data

During the planning of the MPCS, a study protocol describing confidentiality measures was submitted to the Human Subjects Review Committee at Lemuel Shattuck Hospital and approved in September 1985. The MPCS data has also been designated as confidential, pursuant to Massachusetts General Laws Chapter 111, Section 24A, to be used for research purposes by the Massachusetts Department of Public Health. This authorization extends to the end of the grant period.

Additionally, all women in the MPCS were assured that their responses would be confidential and that their names or any other personal identifiers would never be linked to the data. This rule of confidentiality is enforced through the use of an identification number which replaces the participant's name on the questionnaire and data files.

Data collection methodology and data collection personnel

A mixed mode strategy of data collection was employed. Three successive, timed mailings of questionnaires and reminders went out to women in the sample. Non-respondents to the mail survey were followed up by phone or home visit for personal interviews. The mail strategy was omitted for teens under age 18 and women who had suffered adverse reproductive outcomes; these women were sent a letter informing them of the survey and were then contacted directly by phone or by home visit for an interview. Women in the sample who had given their babies up for adoption were not included in the study.

The survey questionnaire was available in English, Spanish, Portuguese, and Haitian Creole. Bilingual telephone and field interviewers were used.

Response Rate 83.8% (2587 women responding)

Analyses and Subanalyses

The outcome measures or dependent variables in the analysis of factors influencing prenatal care utilization are *adequacy of prenatal care utilization* (as defined by trimester of first prenatal care visit and total number of visits adjusted for gestational age at birth) and *trimester of registration for prenatal care*. Ordinal logistic regression was used for this analysis.

In addition to the primary analysis, other analyses currently underway with the MPCS data include:

- an analysis of recall of prenatal care utilization by mothers of infants with adverse reproductive outcomes vs normal deliveries
- an analysis of r ial differences in the number of prenatal care visits in late p. gnancy
- an analysis of the adequacy of occupational information on the survey as compared to that reported on the Massachusetts birth certificate
- an analysis of the effect on response rate of a mixed mode methodology of survey data collection
- an analysis of the effect of Hispanic classification on perinatal statistics and understanding of barriers to prenatal care: comparison of birth registry and survey data
- an analysis underway with Dr. Milton Kotelchuck using the MPCS data to test the Kotelchuck Index of Adequacy of Prenatal Care.

For additional information on the MPCS, contact Ellen Gibbs, Prenatal Care Project Director, or Sarah Johnson, Sr. Planner and Research Analyst. They may be reached at (617) 727-5121 or by writing to them at the following address. Prenatal Care Project, Massachusetts Department of Public Health, 150 Tremont Street, 2nd floor, Boston, Massachusetts 02111.

APPENDIX C

MASSACHUSETTS PRENATAL CARE SURVEY
PRELIMINARY MULTIVARIABLE FINDINGS ON FACTORS SIGNIFICANTLY
ASSOCIATED WITH ADEQUACY OF PRENATAL CARE UTILIZATION
FOR ALL RESPONDENTS
N=2587

A statistical technique called ordinal logistic regression was used to examine the effects of the independent variables of interest on adequacy of prenatal care utilization. The socio-demographic variables controlled for in the analysis were: maternal age, education, ethnicity/race, family income, parity, and gravidity. After controlling for these factors, the following independent variables were significantly associated with less than adequate utilization:

- No insurance ***
- Too many other problems to go for care ***
- Didn't want people to know about pregnancy ****
- Never used health care site before this pregnancy ***
- Pregnancy not planned ***
- Dissatisfaction with prenatal care **
- Received prenatal care at hospital clinic (compared to private doctor or HMO) *

In this particular analysis, the following socio-demographic variables were also significantly associated with less than adequate prenatal care utilization:

- Single marital status *
- Maternal age ≤ 19 (compared to 25-34) *
- Maternal age 20-24 (compared to 25-34) *
- Income ≤ $10,000 (compared to income > $20,000 ***
- Income $10,001-20,000 (compared to > $20,000) **
- Pregnant more than three times *

The overall model was significant:

$X^2=745.53$, $p < .0001$

Key: * = $p \leq .05$
** = $p \leq .01$
*** = $p \leq .001$
**** = $p \leq .0001$

HEALTHY START

A PROGRAM OF CARE FOR PREGNANT WOMEN

Healthy Start is a program that will pay for quality maternity care, if you meet certain guidelines. You may qualify!

Am I eligible?

You may be eligible for Healthy Start if you:

- are pregnant
- have no other insurance coverage for pregnancy care and/or hospital charges
- are not eligible for Medicaid
- meet Healthy Start income guidelines
- live in Massachusetts
- choose a doctor, nurse midwife, health center or hospital participating in the Healthy Start program

What services will I receive?

Healthy Start pays for the cost of care related to pregnancy, including:

- a pregnancy test
- pregnancy care with a participating private physician, nurse midwife, health center or hospital clinic
- pregnancy related lab tests and prescriptions
- assistance in finding other services you may need during pregnancy
- all hospital labor and delivery costs
- one health care visit for you after delivery

How can I sign up?

Please call our toll free number.

1-800-531-BABY.

(1-800-531-2229)

You can apply by phone. Or, write for more information at:

Healthy Start
Department of Public Health
Division of Family Health Services
150 Tremont Street, 3rd Floor
Boston, MA 02111

Remember: you and your baby deserve a healthy start

- Early pregnancy care helps you have a healthier baby—get care as soon as you know you are pregnant.
- Eat plenty of nutritious foods. Good for you, good for your baby
- Cigarettes can harm your baby. So can alcohol and drugs. If you use these, your baby does too. Avoid them all.

If you have any questions about your pregnancy care, please call us at.
1-800-531-BABY (toll free).
(1-800-531-2229)

You and your baby deserve the best of health care. The best care includes regular visits to a health care provider beginning in the *first months* of your pregnancy.

Department of Public Health
Commonwealth of Massachusetts
Michael S. Dukakis, Governor
Philip W. Johnston, Secretary of Human Services
Bailus Walker, Jr., Ph D., M.P.H., Commissioner of Public Health
Charles M. Atkins, Commissioner of Public Welfare

Closing the Gaps:
Strategies for Improving the Health of Massachusetts Infants

Executive Summary

Task Force on
Prevention of Low Birthweight and Infant Mortality

Report to the
Massachusetts Department of Public Health

May 1985

Publication: #14199-10-1000-10-85-C.R.
Approved by Daniel Carter, State Purchasing Agent

Executive Summary

In September, 1984, Massachusetts Public Health Commissioner, Dr. Bailus Walker, Jr., appointed a nineteen-member Task Force on Prevention of Low Birthweight and Infant Mortality. This action was prompted by increasing national and state concern about trends in these sensitive indicators of health. In Massachusetts, the infant mortality rate increased from 9.6 infant deaths for every 1,000 live births in 1981 to 10.1 in 1982. This was the first increase in nine years and the largest in seventeen years. Additionally, comparable to trends across the country, the infant mortality rate for blacks in Massachusetts was more than double that for whites, and significant variations in rates among Massachusetts communities persisted.

The Task Force was asked to address low birthweight as well as infant mortality. Two-thirds of infant deaths are associated with low birthweight, and much of the recent progress made in reducing infant mortality is the result of improved survival rates for babies rather than prevention of low birthweight. National experts have concluded that low birthweight prevention would contribute significantly to further reductions in infant mortality and improved child health. Surviving low birthweight infants are at increased risk for health and developmental problems.

In formulating its findings and recommendations, the Task Force focused on areas where the state could improve upon existing efforts that contribute to prevention of low birthweight and infant mortality. Massachusetts currently offers a range of services and programs that address these problems, and in the past few years, the Commonwealth has taken numerous steps and invested resources in strengthening and expanding these programs. The Task Force's report is intended to provide guidance to the state in building on the current system to achieve further progress, particularly in preventing low birthweight.

The Task Force on Prevention of Low Birthweight and Infant Mortality found gaps in rates of low birthweight and infant mortality among vulnerable populations in the state as well as gaps in resources and services available to pregnant women, infants, and their families across the state. It concluded that there is unequal opportunity for infants to grow up healthy in the Commonwealth, and that these gaps must be closed if Massachusetts is to maintain and further its progress in preventing avoidable infant death and disability. The opportunity for every infant born in the Commonwealth to enjoy healthy development must be maximized. A summary of major findings and recommendations is presented below.

TASK FORCE FINDINGS: WHERE ARE THE GAPS?

Massachusetts' rates of low birthweight and infant mortality generally are lower than those for the nation and other states, although in 1982, twenty-three (23) other states recorded lower infant mortality rates. While the state's infant mortality rate declined to 9.0 infant deaths per 1,000 live births in 1983 (compared to 9.6 in 1981 and 10.1 in 1982), the Task Force's findings of gaps in rates among different groups as well as gaps in services indicate continuing cause for concern.

1. Gaps in Rates of Low Birthweight, Newborn and Infant Deaths

Infant death and disability occur across the state in every racial, ethnic and age group, but gaps between groups can be identified.

- By Race and Ethnicity

While rates of low birthweight and infant mortality have been declining among all racial and ethnic groups, the gap between rates for black and white infants has been roughly double during most of the past decade and appears to be widening. Rates for Hispanic infants appear to fall in between rates for these other two groups.

- By Geographic Area

Rates for communities such as Springfield, Holyoke, and Boston consistently exceed the state rate, and are more than double rates for communities such as Plymouth, Weymouth, and Newton.

- By Income Level

Babies born to poor women are 1 1/2 times more likely to die than those born to women in higher income levels. The racial and ethnic groups and communities in Massachusetts that have high rates of low birthweight and infant mortality also contain high proportions of the poor.

- By Age

Rates for teenagers, particularly young teens, are consistently higher than those for older mothers.

2. Gaps in Access to the Health Care System

One of the most basic prerequisites to promoting infant health is the provision of health care to mothers and their infants before, during, between, and after pregnancies. Massachusetts offers these services through a range of private and publicly subsidized providers and programs, including physicians in private practice, community health centers, hospitals and health maintenance organizations. The Task Force found barriers to obtaining these services which most directly affect the high-risk groups identified above.

- Utilization of Prenatal Care

After steadily increasing until 1981, the percentage of women receiving adequate prenatal care (as defined by when care began, how many visits occurred, and adjusted for the baby's gestational age) has recently begun to decline.

The women in groups and communities with high rates of low birthweight and infant mortality also are often less likely to obtain adequate prenatal care and to register early for care.

Babies born to women who have no prenatal care have a neonatal mortality rate ten times greater and a low birthweight rate five times greater than women who receive adequate care.

- Affordability of Care

It is estimated that approximately 6,000 Massachusetts women are uninsured by either Medicaid or private insurers for maternity care.

Health insurance policies may exclude coverage for maternity services for the self-insured, for women insured under individual rather than family policies, and for minor dependent teenagers.

Women insured through Medicaid may not be ensured access to reproductive and maternity health care throughout the state due to low Medicaid participation of obstetricians and gynecologists in some communities.

- Other Barriers to Care

Transportation, as well as linguistic, cultural and attitudinal barriers serve to impede utilization of services by women and infants, particularly by high-risk groups.

3. Gaps in Components of the Health Care System

To be effective, prenatal care must be comprehensive, addressing the inter-related factors associated with low birthweight and infant mortality. These include poor nutrition, smoking, alcohol and drug use, inadequate spacing between pregnancies, stress, infections, and premature labor. Gaps in services needed to address these factors were found in the Commonwealth.

- Private Physicians

Obstetricians in private practice provide the bulk of prenatal care in this state. They generally do not have the training or access to other resources to enable them to provide all the components of comprehensive prenatal care, particularly for women in high-risk groups.

- Community Health Centers

While generally promoting comprehensive team approaches to prenatal and infant health care, community health centers also encounter difficulties in providing such care. Physicians are difficult to attract, and other health professionals and paraprofessionals (including nutritionists, social workers, health educators, and outreach workers) do not generate revenue. Twenty (20) Department of Public Health Maternal and Infant Care (MIC) projects provide contract support for a comprehensive team model, but MICs and community health centers are not available in all areas of the state. Additionally, they may have difficulty in recruiting minority personnel knowledgeable and sensitive to the language and culture of residents in their service area.

- Categorical Programs

The Women, Infants, and Children (WIC) Supplemental Food Program as well as Family Planning services provide essential components of the comprehensive package of care, but do not reach all who are eligible and in need.

- Regionalized Systems and Infant Care

While the state's informal, regionalized perinatal systems and sophisticated newborn intensive care units may be largely responsible for the reductions in infant mortality in recent decades, the systems have not been formally evaluated. Additionally, follow-up services for high-risk infants and their families are limited.

4. Gaps in Information

While data collected and analyzed by the state provides a solid basis for program planning and policy development, the Task Force noted a few gaps.

- The vital statistics system fails to provide reliable data on both race and ethnicity, hampering understanding of the nature and severity of infant health problems among minority populations, particularly Hispanics.
- A timely mechanism for providing low birthweight and infant mortality statistics to local and regional providers and planners is lacking.
- More specific information on barriers to care, particularly from the women's perspective, would aid in program planning.

TASK FORCE RECOMMENDATIONS: HOW CAN WE CLOSE THE GAPS?

The Task Force's recommendations fall within five broad strategy areas which it believes should form the basis for development of a comprehensive plan of action. The recommendations should be viewed as only the first step in a process which must involve a broad coalition of individuals, agencies, and organizations in the public and private sectors and at the federal, state, regional and local levels to ensure that the identified gaps are effectively closed. While it was charged with making recommendations to guide state action, the Task Force also calls on the federal government to increase its support for measures to reduce low birthweight and infant mortality in Massachusetts and across the nation. The Task Force urges the Governor and the Massachusetts Congressional Delegation to seek federal assistance in implementing a comprehensive plan of action based on the recommendations which follow. Existing federal programs addressed in the recommendations must receive adequate support. The federal government must also [illegible] to new and additional strategies to assure the future health of our [illegible]erable citizens.

1. Strategies to Reduce Low Birthweight and Infant Mortality Must be Specifically Targeted to and Tailored for High-Risk Groups and Areas

Gaps in low birthweight and infant mortality rates between different communities, racial and ethnic groups, and teenage and older mothers must be narrowed to achieve an overall reduction in the state's rates. While each of the other strategies which follow will also address the needs of these high-risk groups, this first strategy is intended to reinforce attention to their needs at local, regional, and state levels.

A. Strengthen existing regional planning through existing regional planning agencies in each of the state's six health systems areas (HSAs). The designated state health planning agency, the Executive Office of Human Services, should develop criteria for components of regional plans addressing maternal and infant health needs and services, and make current state grant awards to these agencies contingent upon their response to the criteria.

B. Promote local and regional coalitions through linkage with and assistance from HSA planning agencies and the Department of Public Health in identified high-risk communities in the state. Award small state grants and encourage local private/public contributions and support.

C. Provide technical assistance to the HSAs and local coalitions through a Department of Public Health team which could aid in needs assessment, planning and program development.

D. Tailor statewide planning and policy development to sensitively and effectively address the specified needs of high-risk communities and groups.

2. Maternity and Infant Health Care Must be Affordable for All

Studies have shown that for every dollar spent on prenatal care, four to six dollars are saved in neonatal intensive care and re-hospitalization for low birthweight infants during the first year of life. Investing in prenatal care would not only help to close the gaps in infant health rates, but would also generate cost savings.

A. Mandate private insurance coverage of maternity benefits on the same basis as benefits for other conditions. Gaps or exclusions in existing policies could be closed with minimal cost to policy holders.

B. Increase enrollment of eligible women in Medicaid through improved intake and referral coordination at local levels, as well as other strategies to be developed jointly by the Departments of Public Health and Welfare. Recently, AFDC income assistance benefits were restored to first-time pregnant women from the beginning of their pregnancies at full state cost. This should increase utilization of Medicaid benefits by these women.

C. Expand eligiblity for Medicaid by continuing to raise standards of need for AFDC and medically-needy related Medicaid coverage until they, at minimum, reach the federal poverty line. The 4% increase in the AFDC payment standard, and 10% increase in the Medicaid-only standard this fiscal year will enable a total of 1900 additional families to receive Medicaid coverage. The additional 5% increase in the AFDC payment standard proposed for FY'86 would further contribute to this goal.

D. Establish a maternity care payor of last resort program to pay for prenatal and delivery care of uninsured women who cannot afford care,

in order to ensure that they come in early and often enough to benefit. The state has already begun to work with private insurers to develop a health insurance plan for low income individuals. Additionally, $900,000 is proposed in the Department of Public Welfare's FY'86 budget to provide maternity care for uninsured low-income adolescents. The state should expand upon this proposal to initiate a program to remove financial barriers to maternity care for all needy uninsured women in the next fiscal year.

3. Comprehensive Maternity and Infant Care Services Must be Readily Accessible to All Women in the State

Ensuring financial access to care is critical, but not sufficient to significantly reduce low birthweight. Comprehensive care addressing medical, nutritional, psychosocial and other key needs must be available and must be tailored to meet the needs of different population groups, particularly those at high risk for problems.

A. Ensure availability of physicians to serve low-income women through increased Medicaid participation and development of a state health service corps program.

B. Expand use of mid-level health professionals, especially nurse-midwives, through third-party reimbursement and support through public health contracts.

C. Promote culturally appropriate care, by training existing providers in culturally-appropriate care for major linguistic and ethnic minority groups, and developing strategies to recruit minority personnel.

D. Establish or expand public health prenatal care programs in critically underserved areas, including Holyoke and other communities with high rates of infant mortality and/or limited access to services.

E. Develop new models for comprehensive prenatal care programs that fit community needs and better link and coordinate resources in a community, particularly in areas without community health centers.

F. Expand WIC and Family Planning Services through advocacy for increased federal funds and strategies to increase utilization of family planning by Medicaid recipients. The state provided supplemental funding to the WIC program in FY 1984 and FY 1985, and 15,000 more women, infants and children are now receiving supplemental nutritious foods and nutrition counseling. While the state at minimum must ensure that the program is funded to continue serving 63,000 recipients, the federal government should be called on to provide funding so that a greater percentage of the approximately 150,000 eligible for the program can be served.

G. Implement comprehensive prenatal care standards statewide by requiring that all care paid for by the state meet the standard and increasing reimbursement and resources to ensure provision of critical components. Medical and other professional organizations should work with the Department of Public Health to adopt existing professional

standards and to encourage adoption of the standard by all providers of prenatal services.

H. Expand high-risk infant follow-up services to ensure support to families once infants leave the hospital.

4. Every Woman of Childbearing Age Should Be Well Informed About Factors Contributing to Healthy Babies and About Availability of Services

If women are to utilize available services to maximum advantage, they must be aware of those services and the importance of utilizing them early and continuously. Information on factors affecting birth outcomes, particularly the importance of early, continuous comprehensive prenatal care and how to obtain it, should be available to all women, but should be specifically targeted to high-risk groups, including low-income, minority and teenage women.

A. Conduct a statewide media campaign that provides information on factors promoting healthy birth outcomes, stressing the importance of early prenatal care and how it can be obtained.

B. Conduct intensive community-based outreach in high-risk areas through community organizations.

C. Provide ongoing support for outreach through specific contractual support for existing programs and innovative community-based models.

5. Ongoing Monitoring of Maternal and Infant Health Status and Needs Must be Strengthened

Effective policies and programs to promote infant health must be informed by timely and useful data.

A. Improve statewide data collection by improving its timeliness, collecting data on both race and ethnicity on the birth certificate and develop other mechanisms for improved needs assessment, particularly on specific barriers to care.

B. Disseminate timely data to regional and local entities to aid in program planning and evaluation.

C. Periodically review infant deaths and regionalized perinatal systems on a statewide or regional basis to evaluate service systems and identify problems.

Mr. WEISS. Thank you very much, Dr. Havas.

Dr. Johnson, I would like to get a better idea of the number of pregnant women who do not have health insurance or Medicaid. For example, at the 100 percent of poverty level or below, how many pregnant women in New York or Texas would need to pay for prenatal care themselves?

Dr. JOHNSON. The answer is clearer for Texas than it is for New York. For Texas, in round numbers, there are 57,000 women who are at 100 percent of poverty or below and do not have either insurance or Medicaid. For New York, the figure that we have is approximately 8,500. But this excludes New York City and only applies to upstate New York.

Mr. WEISS. Why do you think there would be such a difference between those two States?

Dr. JOHNSON. Well, the need levels depend upon three things basically: The number of poor women in the population who are having infants; the extent of insurance coverage within the State; and then third, the eligibility cutoff for Medicaid. In Texas it happens to be 35 percent of poverty.

Mr. WEISS. In order to substantially improve access to prenatal care, and thereby decrease infant mortality and low birthweight, what would you recommend as changes in eligibility for Medicaid?

Dr. JOHNSON. Well, I think looking at the figures, my recommendation would be to fix Medicaid eligibility at 185 percent of poverty for pregnant women, which would help States leverage their local dollars.

There is something else that I would not want to be missed here, and Massachusetts provides an apt example for this. The States are really trying. There are many prenatal care efforts out there. In many respects the leadership is coming from the States, but they need help. If Federal dollars were there to leverage State dollars, I think most of this need could be addressed.

Mr. WEISS. How many women at or below the 185 percent of poverty level would qualify for free prenatal care under your recommendation, who currently have no insurance or Medicaid?

Dr. JOHNSON. Well, across these 10 States at least, it would be about 250,000.

Mr. WEISS. And I assume—and you have already indicated—that this would be a cost-effective strategy. Is that right?

Dr. JOHNSON. Oh, indeed. I think all the evidence points in that direction.

Mr. WEISS. Do you have any numbers to indicate what the total amount of savings or costs would be?

Dr. JOHNSON. Well, I think it is probably—I think I would rather defer an answer on that and give you a more detailed answer. It is not something that——

Mr. WEISS. If you would submit it for the record, we would appreciate it.

Dr. JOHNSON. Indeed.

[The information follows:]

Estimates of cost savings range from approximately $3 to as high as $10 for each dollar expended on prenatal care. Other research has indicated that about 25 percent of the nearly $3 billion in neonatal intensive care costs are avoidable.

Mr. WEISS. Your research makes a major contribution to our understanding of the needs of poor pregnant women. Are there any other studies like it?

Dr. JOHNSON. There are other efforts to arrive at similar information. I think what is special about this is having information on actual pregnancy cases and also information about how they paid for their prenatal care. That is what is special about the study, I would say.

Mr. WEISS. Ms. Brown, do you agree with Dr. Johnson about the cost-effectiveness of prenatal care, and do you have any additional estimates?

Ms. BROWN. Well, as you have heard a number of times this morning, the Institute made a cost effectiveness estimate a few years ago, that $3.38 is saved in first year medical costs for each dollar invested in prenatal care. We have done no further calculations. However, because of the experience of going through those estimates, I am attentive to other estimates.

I think ours is one of the lowest. As someone said earlier, it is a very conservative estimate. There are a number of studies of cost-effectiveness of prenatal care. The findings range quite a bit. But they are all on the side of the fence which is that prenatal care is cost-effective. I think that is the key issue. Which assumptions you build into it, how far out you spin the costs, whether it is 1 year of life for the infant—which is what we did—or 5 years or into 10 years when you get school-age costs and so forth—all such factors influence the figures. But the important point is that all of the studies agree that it is cost-effective. The magnitude, however, varies across the studies.

Mr. WEISS. There have been some increases in funding for the Maternal and Child Health Services block grant in the 1980's. But we have very little information about how the money is actually spent on prenatal services. Is this lack of accountability a problem?

Ms. BROWN. I think it is. I think that one of the consequences of the creation of the block grant was that the reporting requirements at the State level were reduced significantly. It is not easy to gain information from individual States on what they are doing with the funds either in a fiscal sense, or in a programmatic sense. And those of us who are interested in this field spend hours and hours on the telephone calling our friends and former colleagues around the country to find out what is going on. It is a very time consuming and inefficient way to gain a picture of the national effort in this area. There is no Federal effort to survey systematically, and make readily available to all interested parties, how those funds are being used, especially in the programmatic area.

Mr. WEISS. Thank you very much.

Ms. Pelosi.

Ms. PELOSI. Thank you, Mr. Chairman. Forgive me. I have two hearings at one time.

Mr. WEISS. I know.

Ms. PELOSI. So, I have to go back and forth. If the clarification that I am asking has been gone over, I beg your indulgence.

We are all aware of the Surgeon General's goal of prenatal care in the first trimester. As a practical matter, frequently people are well into their first trimester before they even know that they are

expecting a child. What we are talking about today is the most important kind of care, a healthy start.

If we had a system of health care in our country where all people would have access to health care, then in the event that women find themselves in the first trimester, a period which is so valuable to the development of the baby, they would be cared for. I don't envy you the task of seeking out people to come in for help because frequently they don't even know that they are in the situation that they are in. So, I see that as a major obstacle.

Every sign points to the necessity of making an effort to ensure that all of our citizens are healthy and able to deal in a healthy way with all of the opportunities that come their way, especially a brand new baby.

If you have already answered this, I'll refer to the record. But do you think that the Surgeon General's goal will be met? Let me start with Dr. Johnson.

Dr. JOHNSON. There were several goals outlined.

Ms. PELOSI. In terms of the first trimester.

Dr. JOHNSON. I think it is possible.

Ms. PELOSI. Are there steps being taken in furtherance of that goal, to reach that goal?

Dr. JOHNSON. Yes. I think we may be taking a positive step through these hearings in regard to the furtherance of that goal by highlighting the issue. On the other hand is it likely that we will attain the Surgeon General's goal, given the current state of affairs? I think it is very unlikely.

Ms. PELOSI. Thank you.

Ms. BROWN. The Department itself recently completed a midcourse review of the 1990 objectives and themselves admitted that attaining the early prenatal care goal is not likely to be met. Of all the goals in the pregnancy and maternity area, I think that one is looking the most stagnant and the least likely to be reached. And that is by the Department estimates.

Ms. PELOSI. What do you see as the major obstacle in reaching that goal? And forgive me if you have already gone over this material.

Ms. BROWN. You are right that that has been the major theme this morning, that is, why are we not getting more women into prenatal care?

The GAO, I thought, made an important point which is that barriers vary by community and they vary by individual women. The factors that seem to make a teenager less inclined to register for prenatal care may be different for an older woman with several children. So, there are variations among communities and among groups of women within the same communities. But these themes of financial barriers, of problems in systems capacity, of problems in securing a provider of care are common themes across the country.

Ms. PELOSI. And so much of the burden to reach the goal cannot rest on teenage mothers-to-be if the record shows that is so. We have to be more aggressive and vigorous.

Ms. BROWN. I did want to respond very briefly to your comment about knowledge of pregnancy: that is, what are we to do with

women who may not recognize that they are pregnant until late in the pregnancy?

You are right. There is a problem in that area, but I think it masks some basic system problems. For example, the links between pregnancy testing services and those that provide prenatal care are often very poor. If a woman, a teenager, is able to get to a clinic to secure a pregnancy test—and those are widely available, for example, in Planned Parenthood clinics and health departments—if the test is positive, and the woman chooses to continue the pregnancy, the link to get her immediately into prenatal care is very poor. She may be given a phone number. Please call such and such a clinic. For a young teenager in a highly stressed environment, simply giving a phone number is often not enough to secure prenatal care.

"Inadequate knowledge of pregnancy" may be a marker of difficulty in getting into care. It is not always intrapsychic factors within the woman, confusion and denial and so forth.

Ms. PELOSI. Thank you. Thank you, Mr. Chairman.

Mr. WEISS. Thank you, Ms. Pelosi.

Ms. Brown, you have testified about the inadequate Federal response to the suggestions of the Institute of Medicine's 1985 report on preventing low birthweight. One of these suggestions was that the Division of Maternal and Child Health Care of HHS should help develop standards for publicly financed prenatal facilities. Has there been any progress on this?

Ms. BROWN. I didn't hear all of what you said. You wanted to focus on the standards of prenatal care?

Mr. WEISS. Well, you have made some recommendations——

Ms. BROWN. Yes.

Mr. WEISS [continuing]. As to what could be done to prevent low birthweight. And one of those that you made was that the Division of Maternal and Child Health Care at HHS should help develop standards for publicly financed prenatal facilities. And I am wondering if you noted any progress on this.

Ms. BROWN. Actually I think that is one area in which there has been movement—I mentioned it very briefly in my testimony—and that is the convening of the expert panel on the content of prenatal care.

You see, what we really have here is a two-pronged problem. One is getting women in the door, into the doctor's office or into the clinic. The second issue, though, is what is done for them and with them once they are in the system. One of the major conclusions of our 1985 effort was that we have problems in both areas. We are not getting enough women in, and once they are in a system of care, particularly high risk women, we don't have an adequate science base and often an adequate practice base to give them what they need.

So, we suggest that, particularly for settings like a community health center that by definition addresses a very high risk group, we need a much better and deeper understanding of what these women require to improve their chances of a healthy birth outcome. And it was in that context that we recommended standards and further research on the content of care. I think this particular panel that is underway is a very positive step in that direction.

Mr. WEISS. But they are now considering the standards, and there have been no recommendations forthcoming and no standards set yet.

Ms. BROWN. That's correct. But I think there is good reason for that. Prenatal care involves a huge number of interventions. It is a complicated area like much of medicine. And it is hard to develop a clear understanding of what that care should include and of what, in turn, standards might include.

There already exist simple standards. For example, the American College of Ob-Gyn has pages and pages of guidelines on what obstetric care should include. The Select Panel for the Promotion of Child Health some years ago published a list of needed services that include a list of what obstetrical care should include.

But to go beyond that and to get deeper into it, which is what is really needed, does take some careful work. So, I think the fact that we don't yet have clear standards does not necessarily mean nothing is underway.

Mr. WEISS. Do you have any suggestions for us as to what Congress should do to improve the Federal response to your suggestions in that 1985 report?

Ms. BROWN. The issue of leadership has been mentioned a number of times today, and I think it merits underscoring. We need to attend nationally to this problem, and Congress, being a political body, is in a prime position to put this whole issue of prenatal care and infant mortality higher on the national agenda through hearings such as this, through specific legislative action, and so forth.

More specifically, continued improvements in the Medicaid program are always important although, again, I think the complexity both legislatively and at the delivery site level are absolutely overwhelming. Any way that we can make the program both broader and dramatically simpler will be a step in the right direction. Continuing to fund the Maternal and Child Health Services block grant at an increased level is another approach we should pursue.

However, I think we all have to recognize that our prenatal care system—or "non-system," rather—is a patchwork, sort of crazy quilt of programs. At the community level it is very difficult to figure out how these various pieces fit together. And any effort to improve their coordination, to simplify their relationships, to build them together is what I think over time is going to fix the problem, not incremental changes at the margin.

Mr. WEISS. In the prepared testimony that the administration will be presenting later this morning, they suggest that financial barriers are less important than women's attitudes. Now, you quote several studies—and you have indicated in your oral testimony—that show the opposite.

What do you see as the major barriers that poor women face in obtaining adequate prenatal care?

Ms. BROWN. I think we are all beginning to sound like a broken record. The evidence is clear, and it is actually quite uniform; that is, system-based characteristics such as presence or absence of insurance, capacity to find a provider or make an appointment can make the difference.

It is true that there are multiple barriers that influence use. If you think of your own decisions to use or not use a particular service or enroll in a school or choose a play to go to, there are many factors that influence it. And we can't say there is only one, obviously. People don't work at that kind of simplistic level.

But as you look across the studies, urban, rural, teenagers, older women, black, white—there is this constant bubbling to the surface of these issues of financing, insurance, available appointments, distance to travel to a provider and so forth. It is also true—and I think particularly for young teenagers—that absence of information, ambivalence about the pregnancy and related psychological measures are also salient.

But if we are looking from a public policy perspective about what we can affect, I am not sure what we can do about ambivalence about a pregnancy. But I do know what we can do about absence of insurance.

Mr. WEISS. In any event, that ambivalence, that attitude, is only a small percentage of the total problem of lack of motivation or access.

Ms. BROWN. Across studies that is true. But, again, for particular populations it often is important. And again, I would highlight young teenagers. There is a very good study done in Hartford, CT, just of adolescents. And it is one of the few studies we reviewed in which ambivalence about a pregnancy and fear of telling mom and those types of issues seem to preclude early enrollment in prenatal care. But that is one out of many.

Mr. WEISS. Thank you very much.

Ms. Pelosi.

Ms. PELOSI. No questions, Mr. Chairman.

Mr. WEISS. Dr. Havas, Massachusetts recently conducted a study of barriers to prenatal care within the State. According to your testimony, lack of money or insurance, including several related problems such as lack of child care or transportation, was the most important barrier to prenatal care. Negative feelings about the pregnancy, such as not wanting to be pregnant or even think about being pregnant, were also important barriers to care. So, if I understand your results correctly, many women with unplanned pregnancies are at particular risk for inadequate prenatal care. Is that right?

Dr. HAVAS. I'm sorry. I couldn't hear the end of your question.

Mr. WEISS. Many women with unplanned pregnancies are at particular risk for inadequate prenatal care.

Dr. HAVAS. That's correct. Our study found that financial barriers were very significant in terms of access to care. Overall, in our survey, almost a third of those interviewed indicated that one or more financial problems were a major problem in terms of their getting care. And for those who received inadequate care, it was almost 50 percent reported that financial things, either not having enough money, not enough insurance and so forth, were important.

In terms of our survey findings, almost 15 percent indicated that they were unsure about wanting to be pregnant, and another 12 percent said that they did not want to think about being pregnant. Overall, in the survey, it appears that about 40 percent of the pregnancies were unplanned, and this is particularly higher in the teen

community. And we know those people have a problem in terms of access of care. So, that clearly is an issue that needs to be looked at.

Mr. WEISS. And as a result of that finding, the State has increased funding for family planning programs. Is that correct?

Dr. HAVAS. That's correct. We have increased by about $1 million this year. And in addition, the Governor has launched a $1.2 million teen pregnancy prevention initiative.

Mr. WEISS. In July, Secretary Bowen asked Congress to consider legislation that would essentially shift $85 million in Federal funds from family planning matching funds for States to prenatal services for States. I take it that your study results suggest that this would not be a particularly helpful thing to do, since both activities affect prenatal care.

Dr. HAVAS. That's correct. We think, in fact, that more moneys are needed for each of these services rather than trying to pit one against the other and shift from family planning moneys to prenatal care. In fact, since unwanted pregnancies and teen pregnancies in particular can have a serious impact on infant mortality regardless of level of care, I think it is particularly important that family planning moneys and teenage pregnancy prevention projects not receive inadequate funding.

Mr. WEISS. Now, in their study of a small number of poor women served in Boston hospitals, GAO found that only about half received sufficient prenatal care. I believe that most of the GAO interviews in Boston were conducted in mid-1986, which should have included women in the Healthy Start program. Does that finding surprise you? Will you comment on it?

Dr. HAVAS. I think the GAO study dealt with Medicaid women and not women in the Healthy Start program, which would be a different population being served.

The findings of close to—I think 49 percent is what he mentioned of Medicaid patients not receiving adequate care is consistent with earlier findings that we had documented. Our statewide rates—we don't have them broken out for Boston—from several years before indicated somewhere slightly over a third of Medicaid—only a third of Medicaid recipients receiving adequate care.

Part of our efforts in Massachusetts have now been trying to do a lot of outreach and educational efforts to get more of the Medicaid population into care. Some of those are being tied to the Healthy Start efforts or as an offshoot of that, trying to get more women in both programs in early for care.

Mr. WEISS. How did Massachusetts choose the 185 percent of poverty eligibility criteria for the Healthy Start program? And do you think that that level is a reasonable one for other States?

Dr. HAVAS. I think it is reasonable. We did it largely to make things simplified, to make it consistent with other programs, such as the WIC program, which has 185 percent of poverty level as the cutoff level. That way, for example, women who are enrolled in the WIC program and have been determined to become income eligible can automatically be considered as being eligible for the Healthy Start program.

Because of a lot of advocacy that we should, in fact, increase it, we have in the last year, as of July 1, shifted to 200 percent of the

poverty level for the Healthy Start program. But I think in terms of simplifying the system for the rest of the coun y, I think it would be a great leap to just go to the 185 percent.

Mr. WEISS. Expand, if you will, on the problem that you have with uninsured women, totally uninsured women and those who aren't on Medicaid. What is the size of that problem in your State? How are you specifically dealing with it? GAO cited Birmingham, which has a free program for prenatal care, so that people without insurance have a place to go without being concerned about not having money. And, given the testimony we have heard and that you yourself attest to of the savings that are implicit in providing the prenatal care, why would States not be advised to go with that kind of program? Is the Healthy Start program a substitute or a proposal to do that kind of thing?

Dr. HAVAS. Well, in fact, the Healthy Start program is for those that are above the Medicaid eligibility cutoff that is now set at 100 percent of poverty level in the State. And formerly it was an additional 85 percent on top that got covered. Now, we have, as I have mentioned, increased that to 200 percent. So, that is in effect dealing with the uninsured population that is not Medicaid eligible.

We don't have exact numbers in terms of how many women that is. We think it is somewhere around 6,000 women. That is what the estimates of the Task Force on Prevention of Low Birthweight and Infant Mortality estimated. Interestingly, that is also the number of women approximately that are being served annually by the Healthy Start program.

Why aren't other States doing it? It is difficult for me to answer for other States. I think part of it may simply be having to put up the initial amounts of money. Part of it may be lack of familiarity with some of the studies indicating the cost-effectiveness of this kind of care. Part of it may be conservatism of some State legislatures, conservatism of some Governors not wanting to provide additional funds for that. I don't think there is any one answer as to why all States haven't adopted this kind of program.

Mr. WEISS. Is there anything else, before I excuse you with our thanks and appreciation? Is there anything that any of you would like to add at this point on the basis of the questions that have been asked or that haven't been asked?

Ms. Brown.

Ms. BROWN. Just one comment on this substitution of family planning dollars for prenatal care. The evidence that women who have unintended pregnancies begin prenatal care later than women with intended pregnancies is clear. So, if family planning is reduced, unintendedness increases, and it exacerbates the problem of late registration.

Mr. WEISS. Thank you.

Dr. Johnson.

Dr. JOHNSON. Yes. I would just add, in regard to the issue of whether or not the barriers are economic or attitudinal, that within the last year, there were at least five studies which have appeared, all having somewhat similar methodology in that they studied women who had not received adequate care, and queried them for reasons why. Without exception, the most prominent,

single variable that was always noted was inability to pay and lack of insurance.

Mr. WEISS. Dr. Havas.

Dr. HAVAS. I would just like to reinforce the recommendations that were made earlier about increased Federal funding for certain efforts, particularly the Maternal and Child Health grant. I think the concern about there not being enough accountability for those funds could be easily met by writing into the legislation strict reporting requirements for that. I think there is variability among States in terms of how detailed they, in fact report their accomplishments. And I think that that would be a way of getting around that objection.

The other thing. If there were a way to federally mandate that all States provide Medicaid for up to 100 percent of the poverty level, that would be very useful.

Mr. WEISS. Ms. Brown had suggested this difficulty now of finding out what is going on around the country because of the failure of the Federal Government to require that information. And the question I have of you, Dr. Havas, is would you consider that to be an added or difficult burden to carry—that is, of not only compiling for your own purposes, but forwarding on to the Federal Government the evaluations of the various programs that you have?

Dr. HAVAS. Absolutely not. I think it is totally appropriate. And just for your information, I have previously testified before both the House and the Senate on the Preventive Health block grant and have made the same recommendation that there be strict accountability built into that. I think that that was a major weakness of the block grants.

Mr. WEISS. Thank you very much, each of you. I think it has been an important panel, and we have received some very good information from each of you. Thank you.

Our last panel will include Dr. Robert Helms, the Assistant Secretary for Planning and Evaluation at HHS. And he will be accompanied by Dr. Woodie Kessel, Chief of Research and Training Services of the Division of Maternal and Child Health; and Dr. Ross Anthony, Associate Administrator for Program Development of the Health Care Financing Administration. And Dr. Koontz, I think that perhaps you ought to identify yourself before we swear in each of you.

Dr. KOONTZ. I am Chief of the Maternal and Infant Health Branch in the Division of Maternal and Child Health of the Health Resources and Services Administration.

Mr. WEISS. Thank you.

As we have indicated previously, our practice is to swear in all of our witnesses. So, if you would each stand please and raise your right hands.

Do you affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

Let the record indicate that each of our witnesses has answered in the affirmative.

Again, I want to thank all of you for joining us today. And Dr. Helms, we will begin with your testimony.

STATEMENT OF ROBERT B. HELMS, PH.D., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY WOODIE KESSEL, M.D., MPH, ACTING DIRECTOR, DIVISION OF MATERNAL AND CHILD HEALTH PROGRAM COORDINATION AND SYSTEMS DEVELOPMENT, HEALTH RESOURCES AND SERVICES ADMINISTRATION; ANN KOONTZ, DRPH, CNM, CHIEF, MATERNAL AND INFANT HEALTH BRANCH, HEALTH RESOURCES AND SERVICES ADMINISTRATION; JOEL KLEINMAN, PH.D., DIRECTOR, DIVISION OF ANALYSIS, NATIONAL CENTER FOR HEALTH STATISTICS, CENTERS FOR DISEASE CONTROL; AND ELMER SMITH, DIRECTOR, OFFICE OF ELIGIBILITY POLICY, BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE, HEALTH CARE FINANCING ADMINISTRATION

Dr. HELMS. If I may, let me continue the introductions, which you didn't complete. Also with——

Mr. WEISS. Dr. Helms, the amplification system that we have is supposed to be a better one, but it is sometimes difficult to know why or how. You have to bring it very close to you and speak right into the wider of the microphones.

Dr. HELMS. Is that better?

Mr. WEISS. Fine.

Dr. HELMS. As I was saying, I would like to continue the introductions that you started here. Let me ask Dr. Kessel to introduce himself and then Ross Anthony.

Dr. KESSEL. Good morning, Mr. Chairman. My name is Dr. Woodie Kessel. I am also with the Division of Maternal and Child Health in the Health Resources and Services Administration.

Mr. WEISS. Thank you.

Dr. ANTHONY. I am Ross Anthony, the Associate Administrator for Program Development in HCFA.

Dr. HELMS. We also have Dr. Joel Kleinman, an expert on statistics in the Department, and Mr. Elmer Smith from the Health Care Financing Administration, who is an authority on Medicaid eligibility.

Let me say that we have brought these people because of the cross-cutting nature of this issue and the importance that we think the Department gives to this issue.

Mr. WEISS. Dr. Helms, if any of the other witnesses have to testify, then we will swear them in at that point. All right?

Dr. HELMS. All right.

Mr. WEISS. We will proceed at this point with your testimony.

Dr. HELMS. I will submit my longer statement for the record, if that's OK with you.

Mr. WEISS. Without objection, that will be entered in the record in its entirety.

Dr. HELMS. And we would like to cover a shorter statement.

This morning, we will discuss the Secretary's commitment to these issues and review the steps taken to combat the problem. When Secretary Bowen joined the Department of Health and Human Services, he stated that, of all the areas of concern that he had, identifying the causes of infant mortality was among his highest priorities. He directed the Department to focus attention on the

health of our Nation's mothers and children. He established major initiatives to reduce both infant mortality and teenage pregnancy.

I am sure that you are aware of the facts and figures of infant mortality and morbidity. While the United States, infant mortality rate has declined steadily throughout this century, the recent rate of decline has slowed. In 1986, the infant mortality rate was 10.4 deaths per 1,000 live births. For certain racial and ethnic groups and in some areas of the United States infant mortality rates exceed the national rate and are more than double in the worst instances.

The issues related to infant mortality and morbidity have proven to be complex ones, despite substantial efforts by the health community and Federal and State governments to accelerate its reduction.

Low birthweight is recognized as the key determinant of infant mortality and morbidity. In 1985, about 250,000 low birthweight infants were born in this country. Many of these very small babies suffer from long-term disabilities, such as learning disabilities, cerebral palsy, retardation, vision or hearing impairment, and they have a suspected increased rate of respiratory infections. A low birthweight baby places a tremendous emotional and financial burden on the family.

The phenomenon of low birthweight is the subject of much research. While the causes have not been completely identified, we do believe that early initiation of prenatal care is associated with reduced rates of low birthweight.

And what is the solution to reducing low birthweight and consequently infant mortality and morbidity? The solution will require multiple strategies, but enhancing access to prenatal care is one of the Department of Health and Human Services most important efforts. Prenatal care assesses a woman's risk of an adverse health outcome for herself and her baby and attempts to reduce or prevent the consequences associated with that risk. But the key is early diagnosis and treatment.

While medical assessment and treatment are the predominant activities of prenatal care, early care also provides the opportunity to influence maternal behavior which affects the infant's health. The mother's use of cigarettes, drugs and alcohol and her nutritional status are clearly linked to low birthweight, prematurity and miscarriage. With information and counseling provided during prenatal care, these harmful behaviors often can be stopped or modified, resulting in healthier mothers and babies.

Unfortunately, high risk women are the least likely to receive early prenatal care. Despite substantial Federal and State funding, utilization of services has not improved for women in high risk groups. And the frequency of late prenatal care, as well as no prenatal care, has actually increased over the past few years.

We believe that it is our shared responsibility with States and local authorities to address this most important problem. But in my remaining time I would like to look briefly at what the administration has done to reduce infant mortality and morbidity; to increase utilization of prenatal care among low-income women; and then to discuss what we think should be done if we are going to make substantial future progress against this difficult problem.

Our efforts include numerous service programs, research studies, and data and surveillance projects which address early enrollment in prenatal care, the quality and content of the care and the barriers to receipt of care. These are covered in more detail in my statement.

Let me say that these efforts include the Maternal and Child Health block grant. In tables 4 and 5 of my testimony, you can see that maternal and child health expenditures have increased every year since 1981.

In addition, we are targeting special efforts to identify at-risk women, promote early and continuing prenatal care and address gaps in the prenatal service system.

We also have a major effort, covered in the testimony, on basic biomedical and health services research. And the National Center for Health Statistics is working on, and has made marked improvement on, a system to link data from birth and death records in order to assist in effectively identifying high risk populations.

In addition, the Centers for Disease Control in Atlanta, using its surveillance expertise, has conducted special investigations with States to better identify high risk pregnant women.

And of course, there is the Medicaid program where we have made major changes in Medicaid eligibility.

All of these efforts to enhance access of care have not been enough, however. The complexities related to prenatal care have not been effectively addressed. Medicaid women remain at very high risk of an adverse health outcome for themselves or their babies. We have learned that money alone may not produce good outcomes. Therefore, we need to focus on what services are needed and how to deliver these services.

While affordability is a critical component of access to care, the how, what and when services are delivered is far more important. For example, we know that individual and provider attitudes, experience and behaviors have a strong impact on a pregnant woman's motivation and perceptions. Hospitals may be perceived to be intimidating. There may be cultural or language barriers. The importance of obtaining prenatal care may not be well appreciated.

Other barriers to receiving care have to do with availability of maternity care providers, provider participation, the prenatal care services themselves, the location, hours of operation, waiting lines, transportation to and from the place of care, child care services and the scope of outreach systems to recruit hard-to-reach women into care.

As I have stated, the Secretary is personally committed to reducing the unacceptably high rates of low birthweight and infant mortality in the United States. To that end, the Department is proposing the Infant Health Demonstration Act, a special program to test the effectiveness of providing case-managed, comprehensive services—medical, educational, nutritional and psychosocial—to pregnant women, including teenagers, at high risk of having low birthweight infants.

The Secretary's Infant Health Initiative grew out of demonstration projects and other research which indicated that money alone was not enough to markedly improve infant health. We believe that focusing resources, coordinating services, and working through

a case-management approach to address infant mortality will yield positive results. The Secretary's Infant Health Initiative would create a program to demonstrate and evaluate innovative methods of providing targeted, case-managed, individualized, comprehensive services to Medicaid-eligible pregnant women and their infants through the first year of life.

We intend to work closely with Governors, State Medicaid programs, and maternal and child health agencies to design, implement and evaluate the effectiveness of innovative approaches to targeting care. Priority would be given to States with areas of high infant mortality that demonstrate a commitment to addressing the issues of high infant mortality and low birthweight among Medicaid-eligible women. Evaluation would be a critical component since the purpose of the initiative is to find the right mix of services for reducing infant mortality and morbidity among high risk groups.

I wish to emphasize that the key to reducing infant mortality and low birthweight is not additional funding, but intervention strategies carefully targeted to high-risk areas, aggressive outreach for case finding, case-management to assure appropriate referrals and continuity of care, standardized risk assessment, expanded patient education services, extensive followup and active community participation in the design and implementation of interventions.

We know that each of these key components contributes to reduced low birthweight, neonatal mortality and post neonatal mortality. What we don't know is the optimal set of program components necessary to effect these desired mortality and morbidity reductions for the at-risk group.

We believe that with your support we can launch this initiative and take action where it is needed. Mr. Chairman, our children are our greatest national resource. The Secretary is committed to reducing infant mortality and morbidity. And we trust that our efforts toward that end will be supported.

Thank you.

[The prepared statement of Dr. Helms follows:]

ACCESS OF POOR WOMEN TO PRENATAL CARE

Presented By:

Robert B. Helms, Ph.D.
Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
Room 415F, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

For the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations
Rayburn House Office Building, Room B-372
Washington, D.C. 20515

September 29, 1987

TESTIMONY, ACCESS OF WOMEN TO PRENATAL CARE

Mr. Chairman, I welcome the opportunity to appear before you today to discuss our common concern about low birthweight babies and infant mortality in this Nation. This morning I will review the problem, discuss the steps the Administration has taken to combat the problem, and ask your support for the Secretary's proposal to attack the problem head-on at its source.

The Problem

While the United States' infant mortality rate has declined steadily throughout this century, the recent rate of decline has slowed. For certain racial and ethnic groups and in some areas of the United States, infant mortality rates exceed the national rate, and are almost double in the worst instances.

Infant deaths account for over 70% of all deaths among children under 15 years of age. The latest provisional data released by the National Center for Health Statistics show an infant mortality rate of 10.4 deaths per 1000 live births in 1986. While this rate is the lowest yet in the United States, it still leaves us ranked 17th internationally.

Improving the health of the nation's newborns is of the highest priority to the Department of Health and Human Services. But the issue of infant mortality has proven a complex one, despite substantial efforts by the federal and state governments to accelerate its reduction.

Background

There are two disturbing components in the issue of infant mortality: the first is the differential between black and white rates of infant mortality; the second is our inability to reduce the incidence of low birthweight babies.

Black infants are twice as likely to die before the age of 1 than are white infants. For the period of 1979-84, newborns in the nation's capital had the highest risk of dying--nearly double the national rate! And it is this uneven distribution of low birthweight which is the main reason for the United States' relatively poor international ranking.

The incidence of low birthweight remains unacceptably high. We now have the technology to keep these very tiny babies alive. In fact, the decline in the infant mortality rate can be partially attributed to increased survival of high-risk infants. The Administration has been a supporter of the development of technology to save low birthweight infnats. And while we applaud the success of high technology, we realize that we are treating

the symptoms of unhealthy pregnancies and not solving the problem. Prenatal care which could have largely prevented these unfortunate circumstances is not being fully realized.

Both the racial disparity in observed infant mortality and the increased prevalance of high-risk infants share a common characteristic--low birthweight. Low birthweight (a weight of less than 2500 grams or about 5 1/2 pounds) is the primary cause of death and illness in infancy. There is a much higher prevalence of low birthweight among black infants. And the majority of patients being saved in neonatal intensive care units are low birthweight infants.

In table 1, infant mortality rates for blacks and whites is displayed. As can be seen, there is a striking disparity between rates of the infant mortality for blacks and whites.

In table 2, low birthweight rates by race are shown as well as the characteristics of mothers of low birthweight infants. Again, as you can see, blacks have the highest rates of delivering low birthweight infants.

Low birthweight is recognized as a key determinant of infant mortality and morbidity. In 1986, about 245,000 low birthweight infants were born in this country for a rate of 6.7%. Two-thirds of the deaths in the first month of life and 60% of all infant deaths occur to babies weighing less than 5 pounds. Almost 20%

of these very small babies suffer from long-term disabilities such as learning disabilities, cerebral palsy, retardation, vision or hearing impairment, and they have a suspected increased rate of respiratory infections.

From an economic perspective, using 1984 dollars, every low birthweight baby costs an estimated $13,616 for the initial hospitalization. Ninety-two percent of these infants survive and average more than an additional $1000 in hospital care during their first year. For those with long term disabilities, the lifetime cost is estimated to be $123,000. A low birthweight baby places a tremendous emotional and financial burden on the family.

Although low birthweight is a crucial determinant of infant mortality, an additional component is preventable deaths to infants aged 1 month to 1 year, or during the period termed postneonatal. Table 3 shows the neonatal and postneonatal rates of infant mortality. The major cause of postneonatal death for all groups in the United States is Sudden Infant Death Syndrome, a condition for which nothing, as yet, can be done. However, infections, which are largely preventable, are the second leading cause of death for black and native American postneonates. Hispanics, despite their positive birthweight distribution and neonatal outcomes have a higher than average postneonatal mortality rate. Babies of all races and ethnic groups die from motor vehicle accidents, mechanical suffocation, fires and

homicides. Most of these are preventable deaths, and their frequency raises the issues of access to care and health education. These data demonstrate the complexity of infant mortality and the need to target resources to specific problems.

And what is the solution to reducing infant mortality and morbidity? According to a recent Institute of Medicine report, "...the overwhelming weight of evidence indicates that prenatal care reduces [the incidence of] low birthweight."

Prenatal care assesses a woman's risk of an adverse health outcome for herself or her baby, and provides whatever is necessary to reduce or prevent that risk. The findings of a research study just published in the New England Journal of Medicine suggest that a major contributor to low birthweight among black women in general may be anemia. Anemia (or low hematocrit) is relatively easy to diagnose and there are standard therapies for treating its cause, be it a nutritional or infectious disorder. But the key is EARLY diagnosis and treatment.

While medical assessment and treatment are the predominant activities of prenatal care, early care also provides the opportunity to influence maternal behavior which affects the

infant's health. The mother's use of cigarettes, drugs and alcohol and her nutritional status are clearly linked to low birth weight, prematurity and miscarriage. With information and counseling, these harmful behaviors often can be stopped or modified, resulting in healthier mothers and babies.

Unfortunately, high risk women are the least likely to receive early prenatal care. Despite substantial Federal and state funding, utilization of services has not improved for women in high risk groups. And the frequency of late prenatal care, as well as no prenatal care, has increased over the past few years.

In 1970, 68% of pregnant women began prenatal care in the first 1-3 months of their pregnancy. By 1980, the percent of pregnant women who had care in the first trimester increased to 76%, but it has remained at this level ever since.

STEPS TO REDUCE INFANT MORTALITY AND LOW BIRTHWEIGHT

What has the Administration done to reduce infant mortality and morbidity; to increase utilization of prenatal care among low

income women? Are we abandoning the fight against low birthweight and infant mortality as our critics suggest? The answer is a resounding and emphatic no.

Service Programs

- Maternal and Child Health Services Block Grant
  MCH Block Grant authorizes annual appropriations ($557 million in FY 1988) to 57 eligible jurisdictions to assure quality health services to mothers and children and to reduce infant mortality and morbidity. In chart 4 and 5, you can see that MCH expenditures have increased every year. What is most notable is that states are spending proportionality more Federal money for maternal and child health programs and services than for public health programs in general (chart 4).

- Community Health Centers and Migrant Health Projects
  These centers provide prenatal care to medically underserved pregnant women and are implementing a perinatal initiative to ensure delivery of high quality maternal and infant health services. $445 million was appropriated in 1987 to provide health services at these centers.

- The Indian Health Service, in conjunction with tribal health departments, private practitioners and national professional organizations, provide comprehensive

maternal and child health services. Emphasis is on targeting. Pregnant women are identified and prenatal care is initiated. Special attention is given to the prevention of fetal alcohol syndrome. Over the last 10 years, Native American mortality rates have shown proportionately greater improvement than the rates of blacks or whites.

- The National Institute of Alcohol Abuse and Alcoholism, during FY 1986, launched a major public education campaign aimed at preventing alcohol-related birth defects (e.g., low birthweight campaign was done with the collaboration of a wide range of agencies and voluntary organizations). The NIAAA also does research to identify effective and practical measures to reduce and prevent alcohol-related problems. Over $2 million was spent on this activity in 1985.

- The Special Supplementary Food Program for Women, Infants, and Children (WIC) has been operating since 1974. Approximately 1,500 local agencies serve participants through some 7,100 clinic sites. In 1982, States took over primary responsibility for administering the program, and there has been increased MCH/WIC coordination at the national, State and local

levels in order to provide participants with maximum benefits. Over $1.5 billion in WIC Grants were made to States in FY 1985.

Research

- The research efforts of the National Institutes of Health have been funded at increasing amounts since 1981 ($345 million designated for FY 1988). The Institute has also begun a special research initiative, the Infant Mortality Initiative (funded at $10 million for FY 1988) focussed on the principal causes of low birthweight and ways to prevent it.

- The Maternal and Child Health Division, of the Public Health Service, supports many studies related to perinatal health. In FY 1986, 44 projects were funded at a cost of $5.7 million. Among the current projects are: the development of methods to investigate the behavioral aspect of beginning prenatal care; an examination of financing policy on access to prenatal care and pregnancy outcomes for low income women; and a project which is the first step toward determining whether pre-exam labor is associated with any pattern of uterine activity. The findings will have direct utility in targeting resources and producing greater use of prenatal care among high risk women.

- National Commission to Prevent Infant Mortality, created by Congress, is charged with examining the effectiveness and adequacy of current infant mortality-related programs and policies. The Secretary, in providing $100,000 for the initial organizational costs, reaffirmed his commitment to reducing infant mortality and expressed has optimism about the Commission's work. Recommendations will be made to the President and Congress in 1988.

Data and Surveillance

- The Department of Health and Human Services sponsored a study administered by the National Center for Health Statistics to evaluate the quality of state systems for linking data from birth and death records. This study is a vital step forward in our effort to effectively identify high risk populations. The data system will allow us to target special health care to different geographical areas and specific groups of women. The database will also be valuable for monitoring programs to improve pregnancy outcomes and reduce mortality.

- The Centers for Disease Control (CDC), using its surveillance expertise, has conducted special investigations with states to better identify high-risk

pregnant women. CDC is currently supporting three demonstration projects on smoking cessation in pregnancy is Colorado, Maryland and Missouri. In Fiscal Year 1987, $13 million was spent on infant health activities and $52 million was spent on nutritional surveillance.

MEDICAID

- The National Center for Health Statistics' 1982 National Survey of Family Growth estimated that MEDICAID paid for 10% of all births between 1979 and 1982. Based on 1985 data from State Medicaid agencies, it is estimated that Medicaid paid for about 15% of all women giving birth. And since 1985, mandatory Medicaid eligibility for pregnant women and their infants has been extended to cover a substantially greater number of pregnant women.

Recent changes to the Medicaid statute have expanded eligibility and coverage of services for pregnant women and infants. These changes, enacted in the Deficit Reduction Act of 1984 (DEFRA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Omnibus Budget Reconciliation Act of 1986 (OBRA) are outlined below. In addition, the Immigration Reform

and Control Act of 1986 provided exemptions that allow women and children who are seeking permanent resident status to receive Medicaid benefits.

DEFRA provides optimal maternal and well-baby coverage (AFDC financial eligibility requirement must be met) to first time pregnant women from verification of pregnancy. It includes two-parent families if the principal breadwinner is unemployed and children up to age 5 in two-parent families.

COBRA 1985 mandates coverage for all pregnant women who meet AFDC requirements, including two-parent families where the breadwinner is unemployed, and extends coverage through 60-day post-partum care for women who were eligible and receiving care on the last day or pregnancy.

Optional coverage includes coverage for a targeted package of enriched prenatal services (included case-managed services) to specific groups of Medicaid women. OBRA 1986 allowed States to provide Medicaid to pregnant women with incomes between the State AFDC and the Federal poverty level, and extended eligibility to infants up to one-year of age with family incomes up to the Federal poverty level.

Two other significant optimal changes are: States may offer continuous eligibility to women whose eligibility may be intermittent during their pregnancy due to fluctuations in family income; and states may use a presumptive eligibility period, making services immediately available to pregnant women while their eligibility is being confirmed.

By January 1, 1988, 24 States will expand coverage for pregnant women with incomes up to the Federal poverty level. Three States are offering an expanded prenatal care package (Massachusetts, Minnesota, South Carolina) At least 7 States have adopted or plan to use case-managed care: rkansas, Mississippi, New Jersey, California, Rhode Island, Massachusetts and North Carolina.

Examination of Matching Funds reveals that the Federal Government offers substantial financial support to States wishing to expand coverage for pregnant and low income women, particularly among States with historically high rates of infant mortality.

Yet, all of these efforts to provide adequate care have not been enough. The complexities related to providing prenatal care have not been effectively addressed. Even Medicaid women remain at

very high risk of an adverse health outcome for themselves or their babies. What we have learned is that money alone does not produce good outcomes. We need to focus on what services are needed and how to deliver these services.

Barriers to Prenatal Care

What are the barriers to prenatal care? Certainly affordability is one. As enumerated above, over the past few years, the Federal Government has expanded Medicaid eligibility for pregnant women and provided support through the Maternal and Child Health Block grant, Community and Migrant Health Centers, the WIC program and others. At this time, financing is not a major barrier to the reduction of infant mortality. How, what and when services are delivered is far more important.

Besides financial constraints, studies from the Robert Wood Johnson Foundation, the Children's Defense Fund, the Institute of Medicine, Public Health Service and others have shown similar patterns of factors which impede access and early use of prenatal care. Individual attitudes, experience and beliefs have a strong impact on the pregnant woman's motivation and perceptions. Women may have a fear of hospitals, be concerned about cultural or language barriers, have a low value of prevention or not know how to obtain care.

Other barriers to receiving prenatal care have to do with availability of maternity care providers, the prenatal care services themselves, the location, hours of operation, waiting lines, transportation to and from, childcare services and the scope of outreach systems to recruit hard-to-reach women into care.

The Secretary is committed to reducing the unacceptably high rates of low birthweight and infant mortality in the United States. To that end, the Department is proposing to fund The Infant Health Demonstration Act, a special program to test the effectiveness of providing case managed comprehensive services (medical, educational, nutritional and psychosocial) to pregnant women (including teenagers) at high risk of having low birthweight infants.

The Infant Health Demonstration Act

The Secretary's infant health initiative grew out of demonstration projects and other research which indicated that money alone was not enough to markedly improve infant health. One particularly illuminating finding came from a 1986 study of Medicaid women in Guilford County, North Carolina (Buescher). In this study, women receiving case-managed comprehensive prenatal care in the County Health Department were compared with Medicaid eligible women in the county receiving care primarily from

private-practice physicians. The women under the case-managed system had significantly fewer low birthweight infants (8.3%) than the Medicaid women (19.3%), even after controlling for various maternal characteristics and risk factors. The author concluded that a case management approach and greater use of services appeared to contribute to better birthweight outcomes in the health department.

Current methods of providing health care to Medicaid eligible pregnant women and others too often suffer from poor coordination and lack of individually tailored interventions. Added to these difficulties is the fact that many women are poorly motivated and unable to assure that they and their infants receive appropriate care. Integrated multiple services are needed to achieve the desired health status. We believe that focusing resources, coordinating services and working through a case management approach to address infant mortality will yield positive results.

The Secretary's Infant Health Demonstration Act would create a three year program to demonstrate and evaluate innovative methods of providing targeted, case managed, individualized, comprehensive services to Medicaid eligible pregnant women and their infants through the first year of life. We intend to work closely with State Medicaid and Maternal and Child Health agencies to design, implement and evaluate the effectiveness of

innovative approaches to targeting care. Priority would be given to States with areas of high infant mortality that demonstrate a commitment to addressing the issues of high infant mortality and low birthweight among Medicaid eligible women. Evaluation would be a critical component, since the purpose of the Initiative is to find the right mix of services for reducing infant mortality and morbidity among high risk groups.

Numerous projects such as the Robert Wood Johnson's Rural Infant Care Program, the OB Access Pilot Project in California, Title V projects like the Colorado Low Birth Weight Prevention Project and the South Carolina Resource Mothers Project, have shown results which strongly suggest that regionalized enhanced comprehensive pregnancy care can be effective, especially for a vulnerable population such as Medicaid recipients and other low income women.

Some of the results include significantly lower rates of low birthweight infants (among teenaged mothers as well), less perinatal mortality, increased utilization of services, and reduction in high risk behaviors (smoking, alcohol consumption). Again, the key is not additional funding but intervention strategies carefully targeted for high risk area, aggressive outreach for case finding, case management to assure appropriate referrals and continuity of care, standardized risk assessment,

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expanded patient education services, extensive follow-up and active community participation in the design and implementation of interventions.

We know that each of these key components contributes to reduced low birthweight, neonatal mortality and post neonatal mortality. What we don't know is the optimal set of program components necessary to effect these desired mortality and morbidity reductions for each at-risk group.

The Infant Health Demonstration Act grew out of research efforts which have found these key components to be effective tools in reducing mortality and morbidity for high risk groups. The goal of the Act is to test similar innovative approaches to providing and managing prenatal and infant care to those groups at greatest risk.

Mr. Chairman, our children are our greatest national resource. We at the Department of Health and Human Services are committed to reducing infant mortality and morbidity and trust our efforts toward that end will be supported.

Thank you.

Table 1

Infant Mortality Rate by Year and Race

YEAR	WHITE	BLACK	AMERICAN INDIAN
1978	12.0	23.1	13.7
1979	11.4	21.8	15.2
1980	11.0	21.4	13.2
1981	10.5	20.0	11.7
1982	10.1	19.6	10.0
1983	9.7	19.2	10.7
1984	9.4	18.4	9.5
1985	9.3	18.1	9.1

Infant Mortality Rates for 1980 by Race and Education

EDUCATION	WHITE	BLACK
< 9 years	15.1	25.6
9-11	13.7	22.5
12	8.9	18.1
13-15	7.4	16.2
16 + years	6.7	13.6

Data Source: National Center for Health Statistics, Division of Vital Statistics.

Table 2

Percent Low Birthweight By Race

YEAR	WHITE	BLACK	AMERICAN INDIAN	HISPANIC*
1979	5.8	12.6	6.4	6.1
1980	5.7	12.5	6.5	6.1
1981	5.7	12.5	6.3	6.1
1982	5.6	12.4	6.2	6.2
1983	5.7	12.6	6.4	6.3
1984	5.6	12.4	6.2	6.2
1985	5.6	12.4	5.9	6.2

*Data available from about half the states.

Data Source: National Center for Health Statistics, Division of Vital Statistics.

Characteristics of Mothers of Low Birth Weight Infants (1984)

	WHITE	BLACK
Age		
< 18 years	3.7%	10.6%
Unmarried	13.4%	59.2%
< 12 years Education	16.0%	33.1%
Prenatal Care Third Trimester or None	4.7%	9.6%

Table 3

Neonatal and Postneonatal Mortality Rates
by Race and Year

Neonatal (under 28 days)

YEAR	WHITE	BLACK
1950	19.4%	27.8%
1960	17.2%	27.8%
1970	13.8%	22.8%
1977	8.7%	16.1%
1984	6.5%	12.4%

Postneonatal

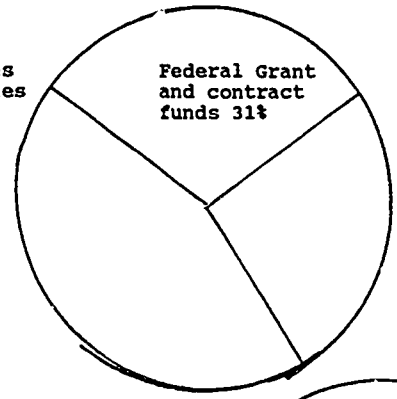
YEAR	WHITE	BLACK
1950	7.4%	16.9%
1960	5.7%	16.4%
1970	4.0%	9.5%
1977	3.6%	7.6%
1984	3.3%	6.6%

Data Source: National Center for Health Statistics,
Division of Vital Statistics.

Table 4

Distribution of State and Federal Funds
for Maternal and Child Health

Sources of Expenditures of State Health Agencies and Local Health Department's FY 1985



FY 1985 MCH Program Expenditures by Source

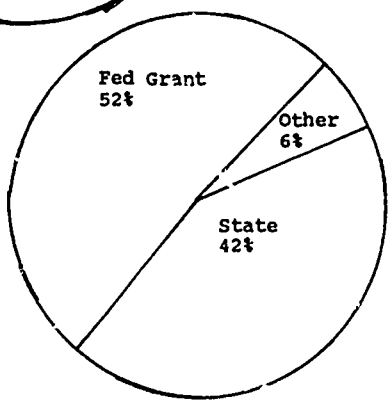


Table 5

Total, HHS Expenditures for Mortality and Low Birthweight (Millions)

1981	$ 27
1982	$ 30
1983	$ 33
1984	$ 60
1985	$ 76
1986	$ 91
1987	$112
1988	$197**

*Health Resources and Services Administration, Centers for Disease Control, National Institute of Health, Alcohol, Drug Abuse and Mental Health Administration, Office of the Assistant Secretary for Health, National Centers for Health Statistics, and the Health Care Financing Administration (targeted demonstrations).

**Includes $85 for the Infant Health Initiative.

Mr. WEISS. Thank you very much, Dr. Helms. I assume that your colleagues and associates will be available to respond to some of the questions, but they don't have independent testimony of their own.

Let me start off, before asking questions, by telling you that I don't have any question at all about the commitment of Dr. Bowen and the sincerity of that commitment to try to reduce levels of infant mortality.

The problem we have is that the suggestion that all kinds of other approaches should be taken, but that money is the least of their problems, flies in the face of the testimony that we have received and what all the studies that have been cited to us say. Yes, there are a complex of factors involved, but the biggest factor is the inability of women to pay for the care. And it seems to me that until and unless that problem is addressed, all the other efforts are going to be certainly inadequate in dealing with the problem.

In 1984, 60,000 pregnant women in the United States received no prenatal care at all, and approximately 140,000 received no care until the last 3 months of pregnancy. Almost half of these women were unmarried. And these numbers seem to hold true for 1987 as well. The percentage of women receiving only third trimester or no prenatal care at all reached a low of 5.1 percent in 1979 and 1980, and rose to 5.6 percent in 1983 and 1984, the same level as a decade earlier. The situation worsened in 26 States and Washington, DC, between 1980 and 1984.

These are very discouraging trends. Do you think they are related to the restrictions on Medicaid-eligibility standards that were imposed in 1981, which resulted in many of the working poor being cut from Medicaid?

Dr. HELMS. It may have had some effect. But I do think access to prenatal care is a much broader problem. I don't know that increased spending is the solution. Again, it gets back to your basic question before—"will massive amounts of insurance and coverage really do something dramatic about access to prenatal care"? I think expanding Medicaid standards would help marginally.

But the situation is that we have looked at what exists and we would like to go out there and try some demonstration projects that get at intensive case-management of the high incidence areas where we know there are severe problems. Let's go see what we can do in these areas and get good information about it. From current research, we really think that targeted case-management will be a productive approach.

Mr. WEISS. The problem that we have, you know, is that that might be acceptable, it seems to me, if the administration was in its first or second year. We are now in the seventh year. We have almost finished 7 years of this administration, and every indication is that the problems have gotten worse during the course of those 7 years than they were when the administration came into office. It seems to me that it is a little late in the game for the administration to suggest that what we need now is some demonstration programs when, in fact, it is quite clear that the approach taken by the administration has been a problem. It seems to me, that by the time you get through with your—never mind your 3-year demon-

stration programs, but even 1 year of that, your administration is out of office. And it is a——

Dr. HELMS. Well, we have a lot of faith in the next Republican administration. They can carry on with it.

Mr. WEISS. Well, I would like to think that whatever the administration is, that their record will be better than the last 7 years of this administration.

Dr. HELMS. Let me point out that there have been a number of changes which we think get at the direct problem in Medicaid. There are new eligibility standards and so on. And we would like to see how these standards are working. We think there is a lot of potential. And we are working to get the word out. There is potential I think for covering a lot of the problem cases out there already.

Mr. WEISS. In July, as you've indicated, Secretary Bowen proposed legislation that would shift approximately $85 million from family planning matching funds to the new demonstration projects that address infant mortality, low birthweight, and related problems. Now, this shift was previously included in the President's proposed 1988 budget, but was not accepted by Congress. Is that correct?

Dr. HELMS. Yes.

Mr. WEISS. According to the Congressional Research Service, the so-called new activities that are described in this proposed legislation are already possible under current law. For example, section 1915(g) of COBRA, passed in April 1986, allows States to offer case-management services as an optional Medicaid benefit. In fact, even section 1915(b) of the Omnibus Reconciliation Act of 1981 allows the Secretary to waive certain Medicaid provisions in order to allow States to establish similar case management systems. I understand that South Carolina has used that authority to develop a program for high risk pregnancies.

That is an accurate statement of the facts and the law, isn't it?

Dr. HELMS. Yes. And we've worked very closely with South Carolina.

Let me say that we think that what you are saying is largely true, and we tried to take advantage of the provisions that are already there. But what we are talking about is a more intensified and targeted effort with which we would like to proceed.

Mr. WEISS. Well, the fact is that the authority to do it has existed since 1981.

In 1986 under the Budget Reconciliation Act, Massachusetts and Minnesota had also taken advantage of that case management option. In your testimony, you list six other States that are planning to adopt case management services under current law. So, can you explain to me what this bill offers that wasn't already available? Dr. Kessel.

Dr. KESSEL. Mr. Chairman, I think the principal feature of this initiative is taking advantage of some of the issues that were raised by earlier witness; those issues being the cooperation and the coordination of bringing the Medicaid programs, working more closely with the maternal and child health programs, providing the experience, disseminating the expertise to the local level in order to

achieve the outreach and the continuous care that was cited earlier.

Mr. WEISS. Well, that's all very nice. But you know, no regulations were ever published by HCFA for the similar case management amendments that were included in the COBRA, the Reconciliation Act, which was passed in April 1986. And these regulations have now been delayed for a year and a half. If the administration supports these kinds of projects enough to introduce such similar legislation, why weren't regulations published for them by now?

Dr. ANTHONY. Sir, you are correct in stating the regulations have not been published, but in actual fact these particular provisions have been implemented through manual instructions and other directions. So, we are working on the regulations and we will try to get them out as soon as possible, but we have not delayed the implementation of the programs. And I think that is the important factor here that the law that Congress put forward has been implemented and is going forward.

Mr. WEISS. Right. So again, either way there is no need for the new legislation. It doesn't really add very much.

GAO expressed concerns about the presumptive eligibility amendments included in OBRA of 1986. The goal of those amendments was to enable pregnant women to qualify for Medicaid immediately if they appeared to meet the eligibility criteria, rather than having to wait for several weeks or months.

Apparently very few States are planning to take advantage of this option because of concerns about how it will work. In fact, one of our very first witnesses this morning from Washington, DC, indicated the problem that she had because there was no utilization of this presumptive eligibility, and her inability to manage the system herself, and that if it were not for a doctor who was willing to do the work for her and provide the care, she would not have received prenatal care.

Now, how is HHS encouraging States to use this option—that is, the presumptive eligibility?

Dr. HELMS. We are doing several things. Again, I would like to ask Ross Anthony from the Health Care Financing Administration to review some of these.

Mr. WEISS. Dr. Anthony.

Dr. ANTHONY. Yes, sir.

I have a survey and some results I think that were provided to you, too, in which we have listed 12 States that have expressed an interest in presumptive eligibility. So, there are a number of States that have worked through the problems. That does not say that there isn't a great need to try to explain the law and to help States work through the difficult problems that you have indicated. The Medicaid program at best is complicated and hard to understand.

It is my understanding that we have a number of efforts under way to do that. The State Medicaid directors and the Medicaid Directors Liaison Committee which works with us have been meeting. As Ms. Brown indicated, we have been working on standards, looking at data sets, and other sources of information on an ongoing basis to try to promote this.

I notice that some of the recommendations—and I have only read the summary of the report I believe you received this morning—

recommend closer coordination and education efforts. And we would be certainly glad to proceed and try to see how we can improve that educational effort and work with the States in that area.

Mr. WEISS. Does HHS have any plans to adopt new regulations or to improve existing regulations so that this option—that is, of presumptive eligibility—will in fact be used by more States?

Dr. ANTHONY. I'm checking with the expert. We do have instructions out, as I had indicated earlier, on some of the other issues. We believe that the law was clear and is self-implementing. And the instructions we feel are clear enough to enable the States to be able to put these programs into effect. That doesn't mean that maybe we shouldn't do a better job at consulting with them and trying to explain them, and if there is a problem or States have a desire to have a closer cooperation or desire to have better explanations, we would be glad to provide those to them.

Mr. WEISS. Well, I would think that you would want to take a very hard look, because every indication that we have is that it is so confusing a situation, that the States are unable or unwilling to participate because they don't know exactly where they will end up with reimbursement.

Dr. ANTHONY. I note your State is one of the 12 that I had listed here. Are you getting that type of feedback from them as they indicate that by next year they will have a program in place? Have they come to you with the difficulties?

Mr. WEISS. The States have been very slow in coming in because they don't really know what the attitude of the Federal Government is. That's the problem that we face.

Dr. HELMS. Let me say that we also have some programs with the Southern Governors Association to try to explain problems in providing services.

One other point I would like to make is that one of the advantages of a case-management approach is that not only would these people be experts in trying to get at the risk factors and trying to change people's motivation and so on once they get them in, these demonstrations would work to find some of the hard-to-find, at-risk people and get them involved. But another thing that they could do, once they are working with these women, is to tell them about their eligibility possibilities, tell them about what their rights are under Medicaid and so on.

It's a difficult problem, but I do think we are working on it.

Mr. WEISS. The problem that we have, Dr. Helms, is that I would find it easier to accept the suggestion that this new legislative approach or initiative that Dr. Bowen has introduced is a real effort if the prior authorization for case management, which goes back to 1981 and 1986, had been implemented. And the fact is that it has not been.

So, it leaves some question in my mind as to whether this is a real attempt or whether it is something that has come out of the bureaucracy to try to suggest that there is a significant new approach when, in fact, it is nothing new at all.

Dr. HELMS. Well, I guess I would take some exception with that because I do think the Secretary is very sincere. I think he has looked at the situation. He says we can do more. And he has stated

his own personal desire that he wants more done in improving infant health. But we are really looking at the problem in terms of trying to get to the high risk areas. And we think that that is what our initiative would do.

Mr. WEISS. Ms. Pelosi.

Ms. PELOSI. Thank you, Mr. Chairman.

This is obviously a very important issue, and there are some very important questions that I have which I would request unanimous consent to submit later.

Mr. WEISS. Without objection.

Ms. PELOSI. Thank you, Mr. Chairman.

If these programs do exist and the regs have not been written, how is it promulgated? How do people know? In terms of delivery of service to individuals, some of these people are the least able to deal with the bureaucracy and, therefore, that creates an obstacle as well.

I also am concerned about your statement that funds for this initiative would be funds previously budgeted for family planning. I think that that is a very serious mistake. Funds certainly should be available for prenatal care and we all agree on that. But I think that our approach to a healthy start, if I may borrow Dr. Havas' term, involves a comprehensive look at when children are conceived and come into the world.

And I would hope that, again, we do not have a competition for the dollar to talk about what is more important when it is all part of the very same thing.

So, I do thank the witnesses for their testimony. I will submit some questions. And thank you, Mr. Chairman.

Mr. WEISS. Thank you, Ms. Pelosi.

[Ms. Pelosi decided not to submit questions.]

Dr. HELMS. Could I comment about the funding?

Mr. WEISS. Please, Dr. Helms.

Dr. HELMS. Let me just say that the reduction in the match for family planning didn't come as an intent to cut family planning so much as it was an overall policy to reduce enhanced matching rates across the board where they existed. We thought a lot of the enhanced matching rates had outlived their usefulness of starting programs.

But the Secretary has already indicated if you don't like that, he would welcome other suggestions of offsets to—there are other ways to fund this.

Mr. WEISS. In your prepared testimony, Dr. Helms, you said that "Financing is not a major barrier to the reduction of infant mortality." And yet, the General Accounting Office, the Children's Defense Fund, the Institute of Medicine, the Massachusetts study, and Dr. Johnson's research, all of which we have heard about today, all show that you are absolutely incorrect.

Now, on what evidence do you base your assumption that financial barriers are no longer a major problem?

Dr. HELMS. I think to a certain extent they are expressing an opinion. I wouldn't——

Mr. WEISS. They are quoting studies. They are not expressing opinions. They demonstrate it by studies.

Dr. HELMS. Yes. I'm, to be honest with you, not as familiar with all those studies, but by training I am an economist. I can't deny that if you had massive amounts of money put into all kinds of insurance programs that you would have a marginal effect on this problem.

Mr. WEISS. Those figures cited to us were that if you would spend $190 million, you would cover the problem of u .insured women.

Dr. HELMS. I don't know about that.

But let me say that our intention is to get at what we think is the real problem of trying to concentrate on the worst areas of the country and the worst sort of at-risk groups that we can identify. We think a lot of work needs to be done, and we are doing a good bit of analytical work to identify these people and try to go after these particular ones.

Spreading a lot of money around has not worked in the past, and I don't think it will work in the future.

Mr. WEISS. Well, again, I don't understand where you are coming from with that. One of our witnesses, from the Institute of Medicine, said that we all sound like broken records because we are saying the same thing, all of us, over and over again, which is that for every dollar spent on prenatal care, within the first year you get back almost $3.50 in savings. So, I don't see where on the basis of the administration's own cost-benefit ratio, which is what I thought was the bottom line approach of this administration, it makes sense not to spend the relatively modest amounts of money which come back in much greater amounts as immediate saving, not even counting what happens years later.

You attempt, Dr. Helms, to place a lot of blame for the lack of prenatal care on poor women themselves. You mention their fear of hospitals, the fact they do not value health prevention measures, and that they are poorly motivated. Now, although nonfinancial barriers are important, the research quoted by the General Accounting Office and the Children's Defense Fund finds financial barriers to be more important than other barriers.

I don't know if you were here earlier to hear our first two witnesses, who were excellent examples of women who very much wanted to obtain prenatal care, but lacked the money to get the care.

Do you have research to back up your claim that women's attitudes toward care, rather than the lack of affordability, are the major reasons why they fail to obtain adequate prenatal care? Dr. Kessel

Dr. KESSEL. Mr. Chairman, I think what we were suggesting was, as you pointed out, that there are, indeed, nonfinancial barriers to accessing care. And those are, as you identified, among the litany of the factors related to why some people don't seek care even when there is financial access to that care.

Certainly affordability is a critical component, as has been stated by Dr. Helms. And we are just emphasizing, I think, what Ms. Brown emphasized that in order to really achieve success in improving the health of mothers and children, we have to be much more aggressive in terms of our programming and effective in our programming in order to make the dollars available more effective.

Mr. WEISS. Well, that's all nice language. But again, let me remind you of the question. Do you have research to back up your claim that women's attitudes toward care, rather than lack of money, is the major reason why they fail to obtain adequate prenatal care?

Dr. ANTHONY. I don't want to give you data, but I have a summary——

Mr. WEISS. You don't want to answer that question either. But you want to say something else. OK.

Dr. ANTHONY. I'll try to answer with the GAO report. And there are some statistics that I find interesting. They say in the first 3 months of a pregnancy, 24 percent of the uninsured don't receive care, 16 percent of those on Medicaid. And in the next paragraph in summary I saw, those citing money as a barrier, 23 percent of the uninsured said that was a barrier, but only 10 percent of the Medicaid population.

Sixteen percent not receiving prenatal care is an unacceptable level from my point of view. But what I find interesting is that only 10 percent felt that money was the barrier.

I spent about 4 years of my life living overseas in the country of Nepal dealing with maternal and child care, setting up a small health project and a community health project in the mountains there. And people do need prenatal care. And I laud your efforts to deal with this subject. But I think that the goal needs to be kept in mind, and that is to prevent infant mortality from occurring.

And again, from a personal point of view, I had a child who, as a matter of fact, was a low birthweight baby born in Johns Hopkins Hospital a couple of years ago. And what struck me is the tragic number of other babies in there who actually were drug dependent because their mothers had been on drugs. There are a number of other factors, smoking, drugs, education, socioeconomic factors, that I think it is important that we not forget.

It doesn't mean that maternal-child care is not an important component. But our opinion is that we need to take a broad look at this problem, and not just hone in on one specific area.

Dr. HELMS. Let me add that Dr. Kessel has assured me that we can certainly give you a number of studies and a list of studies which we think are the basis for going after a case management approach. When you get down to it, I don't think we have any studies——

Mr. WEISS. Can you cite those for me at this point?

Dr. HELMS [continuing]. That say that——

Mr. WEISS. Dr. Helms, can you cite those studies for me now?

Dr. HELMS. No, I cannot right now.

Mr. WEISS. Dr. Kessel, can you cite me those studies now?

Dr. HELMS. We will be glad to supply them.

Mr. WEISS. You know that they exist someplace, but you don't have them at hand. Is that right, Dr. Kessel?

Dr. KESSEL. That's correct, Mr. Chairman.

[The witnesses did not provide information about studies comparing financial and nonfinancial barriers to prenatal care. Instead, they provided information about studies demonstrating the usefulness of a case management approach to improving prenatal care, which follows:]

Case management services, the critical element of the design of the Secretary's Infant Health Demonstration Act, function to monitor receipt of care, facilitate access to necessary services, and reduce barriers to care, such as transportation and child care needs for individuals in need of coordinated, comprehensive health care. These services have been proven to be effective in improving health outcomes for pregnant women and infants, especially for medically and socioeconomically vulnerable groups. The following are the most significant studies to date on case management and comprehensive services for pregnant women.

Sokol, R.J., Woolf, R.B., Rosen, M.G., & Weingarden, K. (1980). Risk, antepartum care, and outcome: impact of a maternity and infant care project. Obstetrics and Gynecology, 56, 153-156.

This landmark study compared two groups of women who received delivery services from the same hospital and had similar demographic characteristics. The study group that received organized multidisciplinary assessment, health education, nutrition services, and ongoing followup to assure receipt of appropriate services experienced significantly lower perinatal mortality when compared with the control group. The addition of a package of comprehensive and coordinated "non-medical" services to traditional care as provided by the project evaluated in this study contributed to the development of current case management designs.

Peoples, M.D., & Siegel, E. (1983). Measuring the impact of programs for mothers and infants on prenatal care and low birth weight: the value of refined analyses. Medical Care, 21, 586-608.

An evaluation of comprehensive prenatal services in a North Carolina maternity and infant care project revealed only minor effects on LBW rates in the study population as a whole, but did demonstrate improvements in the utilization of care and LBW rates in women at high risk. These effects were even more evident for women at very high risk (i.e., non-white teenagers).

California Department of Health Services. (1984). Final evaluation of the obstetrical access pilot project. Sacramento, CA: State of California Health and Welfare Agency.

Medi-Cal eligible women who received enhanced prenatal care services, including psychosocial and nutritional assessments, counseling, and perinatal education, had a LBW rate of 4.7%. This compared with a LBW rate of 7.0% among a matched group of Medi-Cal births to women not receiving enhanced services. The benefit to cost ratio of this progr was estimated to be 1.7-2.6:1 over a short period.

Luescher, P.A., Smith, C., Holliday, J.L., & Levine, R.H. (1987). Source of prenatal care and infant birth weight: the case of a North Carolina county. American Journal of Obstetrics and Gynecology, 156, 204-210.

Women receiving case-managed comprehensive prenatal care in the local health department were compared with Medicaid eligible women in the county receiving care primarily form private-practice physicians; both groups were low income women. The women under the case-managed system (using nurse practitioners) had significantly fewer low birthweight (LBW) infants (8.3%) than the Medicaid women (19.3%), even after controlling for various maternal characteristics and risk factors. The author concluded that " a case management approach and greater use of services ancillary to basic obstetrical medical care appear to contribute to the better birthweight outcomes in the health department."

Dr. HELMS. What I was about to say is that I think the bottom line to the question of "are these attitudes major compared to the economic factors," is that you will never get a definitive answer other than a lot of opinion polls about that.

Mr. WEISS. Well, as a matter of fact, the studies which have been cited to us this morning are, it seems to me, scientific and very detailed studies. And they are not opinions. What I sense is that what you are telling us is opinion. And you are trying to pass yours off as scientific conclusions and the scientific studies that were made by the other people as opinions.

I don't know if you heard Dr. Johnson's testimony regarding the large number of poor pregnant women who have no health insurance or Medicaid coverage.

Does the administration support new efforts to make Medicaid or health insurance more easily available to poor women, particularly the working poor who currently tend to be uninsured? For example, would you support making Medicaid available for more pregnant women?

Dr. HELMS. To a certain extent. We view that our initiative is designed to go after the problem people, the high risk people in the Medicaid population.

We have also launched and encouraged a number of State innovative programs in our welfare reform effort. And there are some States that are coming forward with some plans to extend Medicaid eligibility. And I think that we are going to be looking at these requests very seriously. We are not opposed to considering some of these plans.

Mr. WEISS. Would you support making Medicaid available at a reasonable cost for uninsured women who earn too much to qualify for Medicaid under current regulations?

Dr. HELMS. Not at the present time.

Mr. WEISS. The 1985 Institute of Medicine report and earlier testimony today stress the importance of family planning programs and improving birthweight and access to prenatal care. Yet, Secretary Bowen's proposal would cut the family planning matching funds to States by $85 million, which is almost half. Shifting these funds around in this way is sort of like robbing Peter to pay Paul. How do you justify——

Dr. HELMS. I think I have already covered that topic.

Mr. WEISS. You have nothing to add to it?

Dr. HELMS. Well, the Secretary has already said that if you don't like that proposal, we will be glad to consider any other offsets which you might suggest. We are not hung up on trying to cut that particular program.

Mr. WEISS. We have asked you just a moment ago about making it easier for people on Medicaid to become eligible for coverage and making it easier for uninsured pregnant women to pay for coverage. And you said in the one instance that you are studying the Medicaid eligibility increase and that you are opposed to getting uninsured women covered at this point.

Dr. HELMS. You are talking about a major change in the eligibility standards for AFDC and for Medicaid. And that I think would be something that we would have to look at very seriously. You are talking about a very extensive and expensive change in policy

which has ramifications much larger than in this particular population.

We are doing everything we can under existing eligibility, under the existing rules, to try to locate and encourage people who are eligible for the present benefits to come forward and get the kind of care that we think they need.

Mr. WEISS. Dr. Helms, the problem is that the testimony we have received indicates that the expense, the additional cost, for getting currently ineligible pregnant women covered is so modest—the range that we had was $190 million to $300 million at the outside—and the savings are so enormous by comparison—the very first year alone, $3.38 for every dollar that would be spent—that it just seems to me that, without having really looked at the facts and the studies, you are creating this aura and this fear of tremendously heavy costs when, in fact, all the information indicates exactly the opposite. Not only would you be saving additional lives and providing for healthier infants, but you would end up saving a tremendous amount of money. That is what the facts are indicating.

Dr. HELMS. Let me say that I think what you were asking about—would we be willing to change the rules having to do with the people who are not currently eligible for AFDC—to open this up to people who work and have higher levels of income—as I think you well know, there are I think enormous opportunities to try to do better in Medicaid for people who are much poorer than that. And we think that the problem is among the very poor and we think we would like to concentrate more on that area.

Mr. WEISS. In the President's fiscal year 1988 budget, the administration proposed to limit Federal Medicaid expenditures. According to the Congressional Research Service, in an issue brief dated June 5, 1987, States which had decided to provide optional Medicaid coverage to poor pregnant women under the Omnibus Budget Reconciliation Act of 1986, would not receive Federal matching payments for amounts expended in excess of the State computation. Therefore, the administration proposal would have taken funds away from coverage for pregnant women.

Now, this appears inconsistent with the administration's current concern with increasing prenatal care programs. Can you explain why the administration introduced one proposal to cut the funds and introduced another proposal that increases funds for the same type of services?

Dr. ANTHONY. I think what you are referring to is the cap proposal on Medicaid. It is my understanding—and I will fully admit I am not acquainted with all the details—that the cap was set or was proposed to be set, but that the States had the flexibility within that constraint to allocate funds as they chose.

So, I am not sure that—I think you are correct in that a cap certainly limits funds, and a State might wish to take those in some manner from a specific program. But I don't believe that we indicated you had to take them out of any particular place.

Mr. WEISS. That would have been the result of it.

In your testimony, Dr. Helms, you state that HHS has increased funding for maternal and child health every year since 1980. Now, what funds are included in table 5 of your testimony?

Dr. HELMS. Dr. Kessel tells me that in table 5 is only maternal and infant health figures. The infant mortality and low birthweight really indicates that this started out in 1981, for a total of $27 million. It rose to, in 1987, $112 million, and a request, in 1988 of $197 million.

Mr. WEISS. You have figures on that table running from 1981 through 1988, and the moneys move up from 27 to 30 to 33 to 60, 76, 91, 112, and finally in the proposed 1988 budget to $197 million. Tell me what moneys are included in that. What does that signify?

Dr. HELMS. What I could do is provide you with this page for the record. But in the Public Health Service, there is the Health Resources and Services Administration, within which is the Maternal and Child Health Division. There is CDC, and there's NIH, one, two, three, four, five—seven different institutes in NIH, totaling almost $70 million.

[The table referred to is on p. 179.]

Mr. WEISS. Could you tell me whether these are research funds or services?

Dr. HELMS. These are research funds.

Mr. WEISS. OK. Because the funds for the Maternal and Child Health Services block grant have not been increased every year. In addition, Congress appropriated more funds than HHS proposed for this program in fiscal years 1984 and 1985. In fact, the President proposed a substantial cut in 1984, and has proposed levels that don't keep up with inflation every year since then. When the funding levels are adjusted for inflation, the block grant funds for maternal and child health services have been considerably lower during the 1980's than in the 1970's or late 1960's. In their report, the GAO expressed concern about the inadequacy of these funding levels, especially in the South.

Even with the Federal deficit, wouldn't it make sense for HHS to propose increases in these funding levels given the data on the cost effectiveness of prenatal care?

Dr. HELMS. We adopted a policy with the block grants to maintain these funds pretty much at level funding with a great deal more flexibility for the States to operate within that. They have been at the level of—oh, about over $457 million in 1986 and about almost $500 million in 1987.

I will admit the Secretary is not opposed to additional block grant MCH funding, but we do have budget constraints placed on us just as you do on yourselves.

Mr. WEISS. Well, the Secretary is not opposed. Does that mean that the Secretary now supports the increased support for the program?

Dr. HELMS. I think he has made some efforts to increase support.

Mr. WEISS. Does the administration now support the funding at the proposed $557 million authorization level for fiscal year 1988?

Dr. HELMS. We put in a budget request, they tell me, of $478 million, so we support that.

Mr. WEISS. You don't support the $557 million even though the Secretary is trying to persuade the administration to move to a higher figure than the $478 million. Is that right?

Dr. HELMS. Well, I don't know if it is correct to say the Secretary would really support a specified increase. I think it is more accu-

rate to say that he has supported our budget request of $478 million.

Mr. WEISS. OK.

Dr. HELMS. Which is an increase, and that is what I meant. He does want to emphasize this, and I think that is why he was willing to increase the request.

Mr. WEISS. The fact is then that the Secretary does not propose the increase. OK.

Your prepared testimony includes information on many HHS programs that include prenatal services, but little on how much is spent specifically on prenatal services. Earlier this morning, several witnesses expressed concerns that because block grant funds go to States with virtually no requirements, no accountability, we know very little about how much of the funds are spent on prenatal services and whether the programs are effective.

Does HHS support greater accountability for these Federal funds?

Dr. HELMS. I'm sorry. Your final question?

Mr. WEISS. The question is does HHS support greater accountability for the funds that are spent, the Federal funds that are spent, on prenatal care?

Dr. HELMS. Again, we go back to a basic premise of our block grant proposals to keep all kinds of reporting requirements on the States to a minimum. As a researcher, I can't say that having some more of this information wouldn't be valuable, but we think there might be other ways to get it. And we have certainly supported some efforts to get some information.

Mr. WEISS. Dr. Kessel.

Dr. KESSEL. Mr. Chairman, I think the basic principle also enumerated earlier was in order to keep it simple, to keep the bureaucratic responsibility minimized, that States should spend their time and attention in utilizing those resources to serve their population better.

But certainly we have worked with them and they have shared with us their statistics. We have supported a number of studies in order to identify where there are problems. And through technical assistance and other mechanisms, special projects, we have worked with the States to try and identify the information needed in order to focus and target the problems.

Mr. WEISS. Well, I don't understand what that answer means from the two of you.

If, in fact, the information is shared with you—the statistics are shared with you—then I don't see where there is the additional burden, the additional problem or the additional cost, if it is available already.

The problem that was pointed out to us by all the witnesses earlier is that because there is no requirement, although you may get that information—and I don't know whether you do or not—it is not available to the people in the field or in the other States or localities. And there is no way for them to be able to gauge what programs are working elsewhere.

And again, Dr. Helms, you said as a researcher you think that that kind of information is valuable. The States have no difficulty—I asked Dr. Havas, for example, would it be an additional

burden on the States and would they support having the requirement to submit that information as to how they spend their moneys. And he said no. In fact, he has testified on a number of occasions to make the programs more accountable, and make the States more accountable.

So. I do not know why you would not want that information to be available, not just for your own private use, but for the use of everybody in the field.

Dr. HELMS. Again, it goes back to the basic objective in the overall block grant which was to keep these reporting burdens down. And we didn't want to do that through the block grant mechanism, not just in this program, but a lot of them. But there are other ways to get data and we have supported a number of things in the Health Care Financing Administration.

And also, my office has even taken an interest in trying to promote this idea of research oversight activities, of research in the National Center for Health Statistics to get at matching up the birth data with the death records so that we can identify high risk areas and groups. And we have had substantial progress. We can now get the information within 18 months, and it used to be something like 36 months. We have made a big improvement, and we think this will help a lot in our initiative in trying to find out exactly where the worst problems are.

Mr. WEISS. The Maternal and Child Health Services block grant incorporates a number of programs for which the moneys can be spent. Now, wouldn't you think that it would be helpful to the Department to know on a State-by-State basis how the States are breaking down the money, what they are spending it for? Wouldn't that be worthwhile and valuable information for you to have?

Dr. HELMS. I'm sure we'd get some use out of it, but we still object to requiring it. If we can figure out other ways to get it, fine.

Mr. WEISS. But if the States don't object to giving it to you, why would you object to getting it?

Dr. HELMS. We're getting it. We don't object to it.

Mr. WEISS. Do you publish it?

Dr. ANTHONY. Mr. Chairman, as part of the——

Mr. WEISS. Do you publish it?

Dr. ANTHONY. There is a report compiled, based on the report of intended expenditures which each State submits to us as part of the block grant responsibility. Those have been examined and collated, and they have been sent to the Congress for review in the past.

Mr. WEISS. Do you publish it?

Dr. ANTHONY. It is not officially published, but it is disseminated upon request.

Mr. WEISS. Would you, for our records, submit to the subcommittee, copies of those reports for the last 5 years?

Dr. ANTHONY. We would be happy to, Mr. Chairman.

[The material requested is in app. 3, p. 216.]

Mr. WEISS. Thank you.

In 1985, the Institute of Medicine recommended that the Federal Government should take more of a leadership role in setting standards of care in federally subsidized prenatal programs. Has HHS done anything toward this goal?

Dr. HELMS. I would like Dr. Kessel to respond because I think we have done something there.

Mr. WEISS. Dr. Kessel.

Dr. KESSEL. Mr. Chairman, as Ms. Brown mentioned earlier, we did initiate a public health service expert panel to review the content of prenatal care and make recommendations. As I am sure you are aware, the policy of the Department is not to, per se, set standards but promulgate those standards set by the professional organizations. And in this particular case, it would be the American College of Obstetricians and Gynecologists.

On the other hand, what we have done is initiated some initiatives working with the States to compile I think what Ms. Brown referred to as the minimum standards. Dr. Koontz, I think can explain a little bit more about what we are doing in that area.

Mr. WEISS. Dr. Koontz.

Dr. KOONTZ. I think it was mentioned earlier by one of the witnesses about the Maternal-Child Health Medicaid Program Directors Liaison Committee that has been meeting since the early spring on a periodic basis. As part of the interests of that group, one of their first efforts has been to focus on standards or guidelines more specifically surrounding perinatal services.

They have, in the course of this activity, solicited elected standards from as many States as have been willing to volunteer to send those standards forward. And they are in the process of collating them, examining them and discussing how those would be useful in their respective State programs.

Mr. WEISS. When do you expect the panel's work to be concluded? And what do you expect the ultimate result to be? Do you expect a set of recommendations to be forthcoming from the panel?

Dr. KOONTZ. I would just like to clarify that this is a voluntary group, and it is not a task force. So, there is no defined time period associated with this. They are doing this, coming together to try to enhance the collaborative and mutual efforts that can be obtained through the Medicaid and MCH programs in the States. And so, they have not set a specific time frame for the ultimate completion.

I think that part of their thoughts at the moment—they will consider these in draft and for consideration for guidelines not absolute standards. They do tend to rely on the standards of the professional organizations as those that are ones promulgated.

Mr. WEISS. So, you can't tell us at this point when they will complete their work.

Dr. KOONTZ. They are considering some draft guidelines at this moment. Since that is a group that—I mean, they would have to advise us about when they feel that that work will be complete or at a stage——

Mr. WEISS. Right. You don't know at this point.

Dr. KOONTZ. I don't know what that timeframe is.

Dr. KESSEL. Mr. Chairman, I might add that the work of the expert panel, which is chaired by Dr. Mortimer Rosen from Columbia University, in reviewing the content of prenatal care should be ready by the fall of 1988 after they finish their deliberations.

I might as well point out that most of the literature tends to focus on the medical content of prenatal care and is not very rich in terms of the evaluation of the behavioral aspects the psychoso-

cial care. Although those are very important issues, what I am referring to here is the interventions to precisely respond to those problems in the women that we are concerned about improving their health and pregnancy outcomes.

Mr. WEISS. An HHS funded study by the National Bureau of Economic Research found that early prenatal care is even more important for preventing low birthweight and infant mortality for blacks than for whites. So, it seems that prenatal care could be extremely important in eliminating the enormous racial difference in infant mortality.

Dr. Helms, are you familiar with that study?

Dr. HELMS. No, I'm not.

Mr. WEISS. Dr. Kessel.

Dr. KESSEL. I don't think specifically, sir.

Mr. WEISS. What is your opinion, Dr. Helms, of GAO's recommendation that HHS do more to disseminate the results of studies of prenatal programs that are funded by the Maternal and Child Health Services block grant every year?

Dr. HELMS. I think one of the objectives is to improve. We have no objection to trying to improve the dissemination of useful information. That is one of our objectives for our demonstration, to again do the evaluation of these things, find out what really works, and try to disseminate that information.

Mr. WEISS. Has there been a dissemination of the results of those studies?

Dr. HELMS. Sure. Do you want to——

Dr. KESSEL. Mr. Chairman, to the extent we are working on that issue, we publish every year the results of the demonstration and research projects that the Division of Maternal and Child Health supports. That is sent around to the State maternal and child health directors and the other members of the maternal and child health community.

There are other procedures that we have engaged in to try and address this more effectively through meetings, conferences, workshops, technical assistance activities, directly to the States. And I think Dr. Koontz can elaborate a little bit further.

Mr. WEISS. Dr. Koontz.

Dr. KOONTZ. We have several projects that we are funding that are regional in nature and are specifically targeted to sharing of information among the States in the regions that are involved in the projects. For instance, in region 4 there is a project that addresses perinatal issues and the data and the kind of information and programming that should be implemented.

Currently one of their highest priority issues is to develop an indicator for identifying unmet prenatal care usage. And that meeting was just held last week in Chapel Hill. It involves both State maternal and child health officials as well as State vital registrar officials to bring together two very important components in looking at this issue.

Mr. WEISS. When you get a chance to read the GAO report, will you look at this particular recommendation for more dissemination and give us your response to it for the record?

Dr. KOONTZ. Yes.

Mr. WEISS. The GAO also recommended that HHS develop statistics for each State estimating the cost and savings of making Medicaid available for all pregnant women whose income level is 100 percent of the poverty line or below. GAO thinks that would encourage more States to take advantage of that option.

Dr. Helms, would you support that recommendation?

Dr. HELMS. Well, let me say that I have not looked at the GAO report and neither has the Department in any detail. We will certainly look at that suggestion, as we will all the others, and we will be responding as we always do to GAO reports.

Mr. WEISS. And will you submit the response to that recommendation to the subcommittee please?

Dr. HELMS. I see no reason not to, yes.

Mr. WEISS. I don't either. Thank you.

[The material follows:]

The Office of Maternal snd Child Health (OMCH) currently has a number of approsches to communicste the results of its demonstration projects and to assure disseminstion of important studies in the field to individuals and agencies interested in maternsl and child health issues. Review criteris for demonstration grant approvals stipulate that spplications include a plan and resources to share information about project development and outcomes with local, Stste, regional, and national groups; to accomplish this, project staff may provide presentations at conferences, publish manuals or workbooks, and develop articles for relevant journals. A compendium of abstracts, cited in the General Accounting Office (GAO) report on Prenatal Care, details project gosls, activities, and accomplishments. This compendium is published and disseminsted annually to State maternal snd child health directors and all demonstrstion grant recipients to promote discussion, networking, and replication of successful models by the msternal and child health community. Centrsl and Regional Office consultant staff review published literature for cogent topics, including evalustion research, and forward copies of these to State and local health staff. The OMCH has made s concerted effort over the past two years to include presentations by projec staff at the annual meetings of the Association for Maternal snd Child Health Programs and the Healthy Mothers/Healthy Babies Coalition. Finally, OMCH supports numerous training and continuing education activities esch year which highlight prenatal progrsms proven to be effective in improving health service delivery and health status outcomes.

In light of the recommendations set forth by the GAO report, OMCH is planning to enhance its role in advancing information regarding effective prenatal care programs. The Maternal and Child Clearinghouse, funded by OMCH, has been involved to a limited degree in assisting the agency with dissemination of publications, primarily through the development of the snnual compendium of demonstration grants and msilings of new or existing educational msterials. The staffs of OMCH and the Clearinghouse have met to begin planning for a stronger focus for the Clearingh use in assisting with the synthesis of evaluation data on projects for the purpose of more timely and widely distributed program reports.

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Mr. WEISS. Your preliminary 1986 infant mortality statistics put the United States in 13th place among 20 industrialized countries rather than tied for last place as several witnesses have said. Either is unacceptable as far as I am concerned. But is the new ranking a comparison of 1986 statistics for all 20 countries?

Dr. HELMS. He said it should have read 17th.

Mr. WEISS. It is 17th. And that means——

Dr. HELMS. We would agree that that is unacceptable. The Secretary has so stated and I think that is in my testimony too.

Mr. WEISS. So that if it is 17th, it is still tied for last place. Is that right? Yes. That's the answer.

Dr. HELMS. Tied for last place out——

Mr. WEISS. Out of the top 20——

Dr. HELMS. If you limit the list to your definition of industrialized countries so there are only 17 or 18——

Mr. WEISS. Twenty. Twenty industrialized countries. We had the same information as of 1980. I thought that you had found something new when you said that it was 13th, but apparently not. It is still in the same position.

Dr. HELMS. It hasn't changed, right. No.

Mr. WEISS. Well, that concludes my questions. If you have anything further to add by way of summary, I would welcome it.

I must tell you that for people who are concerned about the quality of prenatal care and about the infant mortality rate and the problems of pregnant women and newly born infants who don't receive sufficient prenatal care, my impression and conclusion is that the administration has at best been marking time. In fact, the statistics indicate that we have been falling further and further behind. And I don't think that you ought to be satisfied any more than I am with the conditions that we find today.

Dr. HELMS. Well, let me respond by saying I don't think the Secretary or any of the rest of us are satisfied. And I think that when the Secretary came in 2 years ago, he established this as a major concern. And I do think we are making some progress.

Mr. WEISS. Dr. Helms, I appreciate that the Secretary came in 2 years ago. The administration came in 7 years ago. And I don't think that it is possible for the administration to pretend that, in fact, it started dealing with the problem only 2 years ago. It started dealing with the problem 7 years ago.

Any further comments?

[No response.]

Mr. WEISS. If not, again I want to thank you very much for your presence and participation. We will keep the record open so that you can submit the responses to the questions that we have asked and also for additional written questions that may come either from the subcommittee or from individual members thereof. Thank you very, very much.

The subcommittee now stands adjourned subject to the call of the Chair.

[Whereupon, at 1:14 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

APPENDIXES

APPENDIX 1.—ADDITIONAL TESTIMONY FROM PANEL 1 MEMBERS

October 23, 1987

Hon. Ted Weiss
Chair of the Human Resources and
Inter-Governmental Relations
Committee of the Committee on
Government Operations
Rayburn House Office Building
Room B-372
Washington, D.C. 20515

RE: Congressional Hearing on
September 30, 1987: Hearing on
Infants at Risk

Dear Congressman Weiss:

At the close of the above hearing you invited me to make recommendations to the Committee, if I had any.

On page 41 of the hearing transcript (line 848), Congressman Lightfoot asked me whether or not a little bit of a supplement would really make a difference to me and my family. If a supplement was available to low-income working families, specifically to pay for private health insurance, it would make a great difference in both our ability to be self-sufficient, and the quality of health care that we receive. With the exception of one very kind doctor at the Whitney M. Young, Jr. Health Center, Inc., I have found that there is little continuity of health care provided at clinics which is often confusing when you are a patient. It would be very helpful if we could pick our own providers.

With respect to a supplement provided for health insurance, it would be helpful if it was on a sliding scale so that as you earn more money, you slowly became self-sufficient.

Finally, as brought out by Ms. Ferrell, while on medicaid, I found that I was treated with very little respect by my caseworkers. I was often called in to bring documents or sign papers which could have been mailed. Because I live 21.5 miles from the welfare center, this was often done at great expense to me. On more than one occasion, I was asked to come in, and then when I arrived, was told that my worker could not see me and that I would have to come back the next day.

I have a son that is on SSI, and I have found that the federal workers there have treated me with much more respect. I would like to propose that medical insurance and medicaid programs be run by the federal government, rather

than through the counties ensure that low-income Americans are treated with respect and courtesy.

Furthermore, I believe that the availability of Hill-Burton coverage is not widely enough known. More should be done to make people aware that Hill-Burton coverage exists.

Finally, it is extremely hard to find doctors that take medicaid. Once you have medicaid, you often have to spend a considerable amount of time, expecially in rural counties, locating doctors that take medicaid patients.

Very truly yours,

Sherrilyn Longacker

Sherrilyn Longacker

Children's Defense Fund

122 C Stree: N W
Washington D C 20001

Telephone (202) 628 8787

October 14, 1987

The Honorable Jim Ross Lightfoot
1609 Longworth House Office Building
Washington, DC 20575-1505

Dear Congressman Lightfoot:

Please let me thank you for the opportunity to appear before the Committee on Government Operations, Subcommittee on Human Resources and Intergovernmental Relations on the subject of access to prenatal care.

As follow up to my testimony and your questions of me, I would like to underscore the importance of the Medicaid program as a means of improving the availability and accessibility of prenatal and maternity care. In recognition of the role that Medicaid coverage can play, Congress last year amended the Medicaid law to permit states to raise the income eligibility level to cover pregnant women and infants with incomes above states' AFDC payment levels but below the federal poverty level.

Adoption of this option in Iowa would have an enormous impact. The National Governors' Association estimates that if adopted, coverage would be available for nearly 5000 poor and pregnant women who are currently uninsured. While the state legislature last spring approved a bill to exercise the option the Governor vetoed the legislation and consequently, Medicaid coverage remains available only to pregnant women with incomes approximately 50% of the poverty level and below.

There are other major Medicaid options available to Iowa that can greatly improve access to care in Iowa. The most important is the option to eliminate the asset test. Traditionally applied to all Medicaid applicants in addition to the income test, the asset test disqualifies many needy pregnancy simply because they have resources in excess of federally established standards.

In states like Iowa the effect of the asset test can be devastating since virtually all farm families are automatically ineligible for coverage because they own farm equipment. Although the equipment cannot help a pregnant woman obtain prenatal care, it is essential to her family as a means of obtaining money to pay for food. If she is forced to sell the equipment to become Medicaid eligible, she is left with no means to make money to feed the family. Under new federal law, states may waive the asset test for pregnant women to ensure that all needy women can obtain care. Yet Iowa has not elected to adopt this option.

Other options that can improve access to care are available to states, as well. States may, at their option, allow pregnant women seeking care to be presumed eligible for Medicaid (if they meet minimal requirements) to avoid the enormous delay that many women face in the determination of their eligibility. By covering women immediately, they may receive needed care early in pregnancy, as recommended by medical experts. (Those found presumptively eligible are covered up to 45 days, or until they are found ineligible, assuming that the woman formally applies within 14 days after presumptive eligibility is granted.) This option is extremely important in communities where few obstetricians will accept uninsured patients, since it provides a mechanism to finance care during a medically critical period when many women do not have adequate coverage. Unfortunately, Iowa, has failed to adopt this option as well.

I hope this information is helpful.

Sincerely,

Dana Hughes, M.P.H., M.S.
Senior Health Specialist

DH:me

APPENDIX 2.—ADDITIONAL TESTIMONY FROM PRIVATE NONPROFIT ORGANIZATIONS

TESTIMONY OF THE

MARCH OF DIMES BIRTH DEFECTS FOUNDATION

ON

BARRIERS TO PRENATAL CARE

SUBMITTED TO THE

HOUSE GOVERNMENT OPERATIONS SUBCOMMITTEE ON

HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

September 30, 1987

The March of Dimes Birth Defects Foundation supports access to maternity care for all pregnant women because comprehensive, early prenatal care has proven effective in reducing the incidence of infant mortality, low birthweight and birth defects. A March of Dimes study based on 1.5 million live births showed that the risk of having a low birthweight baby decreases according to the number of prenatal visits the mother has. Women with no prenatal care at all run a 9 percent risk of having a baby weighing 5-1/2 pounds or less. Women with the recommended series of 13 or 14 visits throughout pregnancy reduce that risk to 2 percent.[1]

In 1979, the surgeon general of the United States established five national objectives for infant health to be reached by the year 1990. One of them was that at least 90 percent of all pregnant women begin prenatal care during the first three months of pregnancy. According to estimates by the Children's Defense Fund, this goal will not be met -- in any state. In 1984, the latest year for which figures are available, only 76.5 percent of babies were born to women receiving early prenatal care.[2,3]

American women continue to have difficulty obtaining prenatal care, despite strong evidence of its benefits. For example: In Orange County, California, the proportion of women who had inadequate or no prenatal care increased from 4.6 percent in 1980 to 6.1 percent in 1986 -- a 33 percent increase. In 1986, the Orange County Health Care Agency actually turned away over

1,600 pregnant women. The survey was conducted in cooperation with the local March of Dimes chapter.[4]

The problem in Orange County is indicative of the scope of the problem nationally. The reasons for the problem: financial and non-financial barriers to accessing prenatal care.

Congress passed legislation last year that is helping to reduce the financial barriers to prenatal care for women lacking private health insurance. The "SOBRA" Medicaid amendments, which allow states to increase income eligibility for pregnant women and young children up to 100 percent of the federal poverty level, have been adopted in 24 states. The March of Dimes strongly supported this legislation both in Congress and in the states. Our goal is enactment of the option in the remaining states so that all women below the federal poverty level will be eligible for maternity services.

The March of Dimes wholeheartedly endorses the Medicaid Infant Mortality Amendments of 1987 (S. 422, H.R. 1018), which would give states the option of increasing income eligibility for pregnant women and infants to 185 percent of the federal poverty level. Enactment of this legislation greatly reduce the number of pregnant women and infants in working families who are uninsured. We commend the House supporters for including this bill in its reconciliation legislation, and urge all members to

support its passage.

Even if all women with incomes below 185 percent of the poverty level become eligible for Medicaid maternity care, there are additional barriers to receiving care.

The Consensus Conferences on Access to Prenatal Care and Low Birthweight, which the March of Dimes funded, identified a number of provider, patient, and "systemic" or public policy barriers to care.[5] We have limited discussion here to barriers that can be addressed through existing legislative initiatives, including:

- o multiple eligibility requirements for benefits.
- o inconvenient hours or location of services.
- o inadequate reimbursement system.
- o inadequate outreach and follow-up.
- o maldistribution of providers.
- o malpractice and liability issues.
- o under utilization of certified nurse-midwives and nurse-practitioners.
- o lack of transportation and child care.

Multiple eligibility requirement for benefits indicates a lack of coordination among existing federal programs. The March of Dimes supports greater coordination among Medicaid, the Maternal and Child Health (MCH) Block Grant, and the Supplemental Food Program for Women, Infants, and Children (WIC). To this

end, we support the study of coordination of Medicaid and WIC as included in the Senate commodity bill (S. 305). The March of Dimes urges the House conferees on the commodities bill (H.R. 1340) to accept the Senate WIC provisions.

The consensus conferences recognized an under-utilization of certified nurse-midwives and nurse-practitioners in obstetrical care.[6] Pending legislation (S. 1441) to reauthorize the Community and Migrant Health Centers would target $35 million to reducing infant mortality by increasing the number of centers and expanding outreach. Training of certified nurse-midwives and nurse practitioners also would be increased in this bill. We urge the House to include these provisions in their Community and Migrant Health Centers bill (H.R. 1326).

Finally, the March of Dimes would like to thank the House members who supported increased appropriation for MCH Block Grant in the Labor, Health and Human Services and Education Appropriations Bill. This is the only federal program that focuses solely on the health of mothers and children. We urge the Senate to maintain full funding for MCH, $557 million, in its Labor, Health and Human Services and Education Appropriations bill, and we ask the House to accept the full funding level when the bill is conferenced.

Thank you for the opportunity to present the views of the March of Dimes on federal programs to address barriers to prenatal care.

1. March of Dimes Birth Defects Foundation. Facts, p.8.

2. American Nurses' Association. Report of Consenses Conferences on Access to Prenatal Care: Key to Preventing Low Birthweight. Kansas City, Mo.: the Association, 1987.

3. Hughes, D., K. Johnson, J. Simons, and S. Rosenbaum. Maternal and Child Health Data Book: The Health of America's Children. Washington, D.C.: Children's Defense Fund, 1986.

4. Professionals and Agencies for Prenatal Access, Preliminary Report on Prenatal Care in Orange County, August 3, 1987, p.2.

5. ANA, p. vi.

6. ANA, p. 27.

NATIONAL PERINATAL ASSOCIATION

"A non-profit organization, dedicated to promoting perinatal health through fostering delivery of optimal care, education, research and orderly of national priorities."

National Headquarters
101½ S. Union Street
Alexandria, Virginia 22314-3323

(703) 549-5523

Testimony for the Committee on Government Operations
September 30, 1987

The National Perinatal Association (NPA) is an organization comprised of 10,000 members including physicians, nurses, social workers, nurse-midwives, dietitians, consumers, and other perinatal professionals. The term "perinatal" refers to the period shortly before and after birth, from the twentieth to the twenty-ninth week of gestation to one to four weeks after birth, we are in essence. concerned with the health of mothers and infants. Our organization is unique in that it represents multidisciplinary professionals brought together under a common bond, the recognition of the need and the desire to improve the health of America's mothers and infants. Among our top priorities are expanding Medicaid, improving access to care, and reducing infant mortality.

NPA recognizes the importance of the access of prenatal care to pregnant women in ensuring healthy mothers and babies. In 1984

NPA passed a resolution to support Federal legislation that provides equal access to high quality care for all pregnant women and newborns. And we continue to work actively to increase access and improve pregnancy outcomes.

The 1984 resolution reads,

> Whereas, the NPA believes that health is influenced by all factors in the human life cycle which affect the well-being of the family prior to conception throught the next generation, and Whereas, the NPA respects the rights of each individual to a wholesome, full life, and Whereas, the NPA believes that a wholesome full life is enhanced by good prenatal care, Be it resolved, that NPA should monitor all Federal legislation and rules and regulations to ensure equal access to high quality care for pregnant women and newborns.

This resolution was based on research that found women who receive early, comprehensive prenatal care experience less complications and give birth to healthier infants than women who receive late or no prenatal care at all. Low birthweight infants is one possible health outcome of inadequate prenatal care. The medical and financial consequences of low birthweight babies are serious; low birthweight infants are twenty times more likely than normal weight infants to die in their first year of life. In addition, those low birthweight infants that survive often suffer from disability throughout their lives and require extensive medical attention.

Providing early, comprehensive prenatal care to pregnant women not only reduces disability, but also reduces costs. The well-known OB Access study in California found that every

dollar spent on prenatal care saved $3.38 in medical care to low birthweight infants in their first year of life. Thus, providing comprehensive prenatal care improves health outcomes and reduces medical costs.

NPA believes in investing in our future generations. The current infant mortality rate in the United States, which is ranked last among twenty industrialized countries, demonstrates that we still have not provided adequately for our nation's children. NPA believes ensuring quality prenatal care to all pregnant women is the first step in building our nation's future.

NPA commends the recent Federal efforts to improve health care for the poor through the Deficit Reduction Act of 1984, the Consolidated Omnibus Budget Reconciliation Act of 1986 and the Sixth Omnibus Budget Reconciliation Act which all expanded the eligibility to Medicaid. In addition, the establishment of the National Commission to Prevent Infant Mortality demonstrates an awareness and commitment to improve our infant mortality rate. NPA urges that Federal action on the problems of access to health care and infant mortality continue.

For further information, please contact Sandra Butler-Whyte, Executive Director, National Perinatal Association at (703) 549-5523.

nachri

ROBERT H. SWEENEY
President

September 30, 1987

The Honorable Ted Weiss
Chairman
Subcommittee on Human Resources
and Intergovernmental Relations
Committee on Government Operations
B-372
2442 Rayburn House Office Bldg.
Washington, D.C. 20515

Dear Representative Weiss:

On behalf of the 96 children's hospitals that are members of the National Association of Children's Hospitals and Related Institutions (NACHRI), I am writing to commend you for addressing in today's hearing before the Subcommittee a problem that has serious implications for the health of our nation's children: inadequate prenatal care.

Children's hospitals are among the first to see the results of inadequate prenatal care. Pregnant women who receive inadequate prenatal care are at significant risk of bearing an infant who is low birthweight, stillborn, or dies within the first year of life. An infant who survives a medically unsupervised pregnancy is likely to be hospitalized in a neonatal intensive care unit at a cost of $1,500 a day, a sum commensurate with the cost of prenatally monitoring an entire nine months of pregnancy. The Institute of Medicine found that every dollar invested in prenatal care saves $3.38 in an infant's first year medical costs alone; testimony solicited at your hearing today disclosed that this estimate is a conservative one indeed. Furthermore, the medical problems suffered by such an infant do not necessarily end at year one; they may persist in a sequelae of impairments throughout the child's life.

Thus, on behalf of NACHRI, I would like to recommend the following as essential steps in assuring prenatal care for impoverished pregnant women:

- Nation-wide adoption of state Medicaid eligibility options for pregnant women with incomes of up to 100 percent of the federal poverty level, as authorized by the Sixth Omnibus Budget Reconciliation Act of 1986;

The National Association of Children's Hospitals and Related Institutions, Inc.
401 Wythe Street, Alexandria, Virginia 22314
Phone (703) 684-1355

- Inclusion of the Bradley-Waxman Medicaid Infant Mortality Amendments (S.422 and H.R.1018) in the Fiscal Year 1988 Budget Reconciliation package to further expand Medicaid eligibility to include pregnant women and infants with incomes up to 185 percent of the federal poverty level; and

- Increased funding for prenatal services in the Maternal and Child Health block grant.

NACHRI offers full support in your efforts to address this crucial problem.

Sincerely,

Robert H. Sweeney
President

RHS/mtb

The American College of Obstetricians and Gynecologists

December 21, 1987

The Honorable Ted Weiss
Chairman, Subcommittee on Human
Resources and Intergovernmental Relations
B372 Rayburn Building
Washington, DC 20515

Dear Chairman Weiss:

The American College of Obstetricians and Gynecologists (ACOG) has reviewed the GAO's recent report on Prenatal Care, GAO/HRD-?"-137, and would like to share with you our comments about the report. At the outset, we commend the GAO for undertaking a study of prenatal care, and more particularly for attempting to determine from the perspective of women themselves, what obstacles low-income women report hindered them from obtaining more or earlier prenatal care.

We would like at the outset to point out that the report issued at the hearing was in error in the reporting of the percent of obstetrician-gynecologists who accept Medicaid patients, as determined by Mitchell and Schurman. Preliminary data from an ACOG survey conducted this year appear to confirm the Mitchell and Schurman estimate that about 64 percent of obstetrician-gynecologists accept Medicaid patients. The College appreciates the GAO's quick action to correct this error.

The authors indicate in Chapter 5 that the study showed "few women had problems finding a physician or other health care provider to see them." Based on the data presented in the report, we strongly disagree. For example, on page 55 it is reported that 11 percent of the Medicaid recipients interviewed encountered problems in finding a doctor to see them. Furthermore, in table 3.1, Barriers to Prenatal Care, by Adequacy of Care, it is reported that of those whose care was inadequate 15 percent indicated that no doctor would see them, 5 percent said that there were no doctors in the area, 17 percent could not get an appointment earlier, and 13 percent said the wait in the office was too long. The percentage of Medicaid women who reported problems in finding a doctor and the frequency with which these obtaining inadequate care cited lack of doctors or long waits, led to a conclusion opposite to GAO's, namely that Medicaid and uninsured women do have significant problems finding a health care provider to see them.

Other anecdotal evidence cited in the report confirms that the women surveyed have difficulty finding a provider. The report quotes local officials in Bluefield, West Virginia, who indicate that many women travel up to two hours to obtain prenatal care; cite a clinic in Charleston, West Virginia, that has closed admissions every year for the past four years because of high patient volume; the report that officials in Los Angeles County mentioned the overcrowded public health clinic system as a major barrier to access to prenatal care. All of these examples suggest to us that there is insufficient capacity in the current system, in many communities, to provide sufficient prenatal care. Provider participation must

(xxx) Maryland Avenue, SW, Washington, DC 20024-2588 (202) 638-5577

be increased and raising reimbursement rates is one way to accomplish this. Consequently, we disagree with the conclusion that raising reimbursement will do little to improve access to prenatal care for most women.

This is not to say that we disagree with the importance of the recommendation that would expand eligibility to 100 percent of the poverty level and enact a presumptive eligibility process. We strongly support these recommendations as well.

The report also notes that higher reimbursement rates would expand the choices of providers available to women obtaining care at a hospital or public health clinic. If the public provider system does not have the capacity to care for all the women requiring care, expanding the capacity of the entire system would help alleviate the problem. From its inception, freedom of choice has far too often been a hope and not a reality for Medicaid beneficiaries. Incentives to encourage greater participation would help provide recipients with the freedom of choice Medicaid has long sought.

There are two other issues relating to source of care that warrant further study. The data indicate that women who obtained their prenatal care at a doctor's office were more likely to obtain adequate care than women who obtained their care at a health department or hospital clinic. It would be interesting to know whether this difference is due to the setting or to characteristics of the women. We would be interested in knowing if there are differences in the cost to the Medicaid program for care provided in the different settings.

Another area of concern involves the findings with respect to women in urban versus rural areas. The report states that women most likely to have adequate prenatal care were women in rural communities, while women most likely to have inadequate or intermediate care were women in the largest urban areas. This finding contradicts other evidence indicating a decline in access to prenatal care in rural areas precipitated by a loss of family physicians and obstetricians in these communities. The fact that 12 percent of women in rural areas cited transportation as the most important barrier to prenatal care could reflect that these women may be forced to travel greater distances to the nearest provider who will see them, and not just the lack of public transportation in these areas. More research is definitely needed.

The difference between the communities included in the survey are striking and point to the need for each community to clearly identify its own needs. We support the recommendations for assistance to communities in developing plans for identifying the most important barriers to care in their specific community and designing programs to help overcome those barriers. We also agree with the Southern Regional Task Force on Infant Mortality that MCH block grant funds need to be increased.

We hope you will find these comments helpful. The GAO report is an important one and one which will be referred to by policy makers in the future, and for that reason these clarifications are important.

Sincerely,

Harold A. Kaminetzky, MD, FACOG
Director - Practice Activities

HAK:R:sm

APPENDIX 3.—STATE BY STATE MATERNAL AND CHILD HEALTH EXPENDITURES FOR FISCAL YEARS 1981–85

1981

APPENDIX TABLE 35. HEALTH SERVICES ADMINISTRATION (HSA) GRANTS AND CONTRACTS EXPENDED FOR PUBLIC HEALTH PROGRAMS OF STATE HEALTH AGENCIES, BY AUTHORIZING STATUTE, FISCAL YEAR 1981

STATES AND TERRITORIES (1)	TOTAL HSA GRANTS & CONTRACTS (2)	HYPERTENSION (SEC. 317(a)(1) PHS ACT) (3)	MATERNAL AND CHILD HEALTH (TITLE V, SSA) (4)	CRIPPLED CHILDREN (TITLE V, SSA) (5)	SERVICES FOR BLIND AND DISABLED CHILDREN (SSI, SEC. 1615(b), SSA) (6)	FAMILY PLANNING (TITLE X, PHS ACT) (7)	EMERGENCY MEDICAL SERVICES SYSTEMS ACT (TITLE XII, PHS ACT) (8)	MIGRANT HEALTH (SEC. 329 PHS ACT) (9)	OTHER HSA (10)
			*	(thousands of dollars)					
TOTAL	$465,685	$19,118	$240,132	$73,623	$9,410	$74,728	$21,245	$2,674	$24,756
REGION I									
CONNECTICUT	4,528	273	2,255	1,081	292	-	313	-	314
MAINE	4,107	185	1,687	786	126	-	1,192	-	131
MASSACHUSETTS	7,298	419	4,559	1,583	644	-	-	-	93
NEW HAMPSHIRE	2,567	79	1,078	585	109	397	297	-	21
RHODE ISLAND	2,327	78	637	637	145	310	170	-	350
VERMONT	1,912	114	570	249	65	381	348	-	186
REGION II									
NEW JERSEY	10,803	929	3,512	1,653	706	3,370	287	-	345
NEW YORK	27,170	1,143	18,343	4,829	-	2,020	706	-	130
PUERTO RICO	25,453	130	7,660	3,265	116	399	914	913	12,056
VIRGIN ISLANDS	2,185	-	1,027	228	-	190	221	-	520
REGION III									
DELAWARE	1,506	25	604	401	-	478	2	-	-
DIST. OF COL.	6,915	16	5,011	1,016	-	-	122	-	750
MARYLAND	12,662	423	6,202	2,418	-	3,619	-	-	-
PENNSYLVANIA	20,122	1,290	10,972	5,444	837	-	-	239	1,340
VIRGINIA	12,763	372	5,212	2,807	51	3,750	-	-	571
WEST VIRGINIA	4,728	217	3,126	-	-	886	47	-	451
REGION IV									
ALABAMA	11,520	491	6,297	-	-	3,768	876	-	86
FLORIDA	15,010	1,151	7,171	-	-	5,901	709	-	78
GEORGIA	17,942	897	7,485	2,950	442	4,618	1,478	37	35
KENTUCKY	10,347	385	4,701	1,594	-	3,511	70	-	85
MISSISSIPPI	11,537	687	5,120	1,709	-	3,311	661	9	41
NORTH CAROLINA	18,239	450	8,428	4,013	637	4,262	-	211	237
SOUTH CAROLINA	12,575	347	4,267	1,613	127	3,815	776	107	1,521
TENNESSEE	13,281	323	4,872	2,546	-	4,352	122	-	1,065
REGION V									
ILLINOIS	9,811	751	8,916	-	-	-	113	-	32
INDIANA	5,944	493	5,414	-	-	-	-	-	37
MICHIGAN	20,085	734	8,204	3,657	1,278	4,795	1,214	-	201
MINNESOTA	8,004	160	3,930	2,472	259	-	916	-	266
OHIO	19,546	694	9,859	3,853	508	2,925	913	-	795
WISCONSIN	5,394	399	4,511	-	-	-	437	-	47
REGION VI									
ARKANSAS	6,703	222	5,233	-	-	1,102	98	-	48
LOUISIANA	10,499	433	5,783	2,155	279	1,849	-	-	-
NEW MEXICO	3,825	68	2,089	760	-	179	729	-	-
OKLAHOMA	6,377	104	3,405	-	-	2,446	113	73	147
TEXAS	19,701	406	11,096	5,112	976	-	1,448	84	579
REGION VII									
IOWA	4,365	104	2,747	-	-	1,262	124	-	129
KANSAS	5,765	356	2,342	1,004	423	905	448	184	104
MISSOURI	7,703	427	5,385	1,378	226	-	287	-	-
NEBRASKA	4,471	252	1,925	-	-	1,214	780	143	156
REGION VIII									
COLORADO	7,648	176	3,662	942	360	926	648	666	270
MONTANA	3,391	99	1,208	425	9	797	854	-	-
NORTH DAKOTA	1,598	88	1,061	16	-	431	-	-	2
SOUTH DAKOTA	2,567	114	1,499	381	74	446	19	8	26
UTAH	4,116	132	2,621	664	134	302	205	-	59
WYOMING	1,625	-	991	235	9	-	390	-	-
REGION IX									
ARIZONA	4,385	145	3,164	883	192	-	-	-	-
CALIFORNIA	16,891	1,471	10,172	4,861	-	-	-	-	387
HAWAII	3,944	57	1,472	551	153	1,080	196	-	436
NEVADA	1,912	6	1,058	419	87	201	-	-	141
AMERICAN SAMOA	339	25	198	69	-	46	-	-	-
GUAM*	-	-	-	-	-	-	-	-	-
NO. MARIANA IS.*	-	-	-	-	-	-	-	-	-
TRUST TERRITORY	634	44	408	109	-	73	-	-	-
REGION X									
ALASKA	1,920	-	661	383	-	-	592	-	284
IDAHO	3,743	100	1,915	675	90	671	267	-	25
OREGON	6,331	229	4,273	-	-	1,325	504	-	-
WASHINGTON	8,948	316	4,134	1,210	55	2,416	639	-	177

* THE PUBLIC HEALTH AGENCIES IN GUAM AND THE NORTHERN MARIANA ISLANDS DID NOT REPORT TO ASTHO/RS FOR FY 1981.

NOTE THE DATA IN THIS TABLE RELATE ONLY TO EXPENDITURES OF OFFICIAL STATE HEALTH AGENCIES. THE PUBLIC HEALTH EXPENDITURES OF OTHER STATE AGENCIES SUCH AS SEPARATE MENTAL HEALTH AUTHORITIES, ENVIRONMENTAL AGENCIES, AND HOSPITAL AUTHORITIES ARE NOT REFLECTED IN THE ASTHO/RS DATA BASE.

1981

APPENDIX TABLE 38. PERSONAL HEALTH PROGRAM EXPENDITURES OF STATE HEALTH AGENCIES, BY PROGRAM CATEGORY, FISCAL YEAR 1981

STATES AND TERRITORIES (1)	TOTAL PERSONAL HEALTH (2)	SUPPORTING PERSONAL HEALTH SERVICES (3)	MATERNAL AND CHILD HEALTH (4)	HANDICAPPED CHILDREN'S SERVICES (5)	COMMUNICABLE DISEASE CONTROL (6)	DENTAL HEALTH (7)	CHRONIC DISEASE (8)	MENTAL HEALTH AND RELATED PROGRAMS (9)	STATE-OPERATED INSTITUTIONS (10)	OTHER PERSONAL HEALTH (11)
			*	(thousands of dollars)						
TOTAL	$3,564,506	$107,434	$1,491,817	$232,167	$145,945	$36,254	$115,214	$283,872	$927,631	$224,172
REGION I										
CONNECTICUT	33,803	1,350	17,915	2,477	1,307	-	1,105	-	7,722	-
MAINE	17,778	448	8,140	1,314	840	202	624	28	-	1,926
MASSACHUSETTS	115,559	130	22,267	3,745	5,957	349	1,193	19,547	60,655	6,182
NEW HAMPSHIRE	8,172	503	5,831	944	414	165	298	18	-	1,716
RHODE ISLAND	13,771	684	7,835	709	1,033	289	779	-	-	-
VERMONT	11,750	192	7,829	676	481	732	127	-	-	2,441
REGION II										1,713
NEW JERSEY	72,300	153	27,829	4,605	4,095	226	2,608	23,385	-	9,398
NEW YORK	237,926	685	87,490	1,025	2,762	590	4,414	-	79,919	61,042
PUERTO RICO	272,517	-	47,585	3,382	3,287	1,217	1,133	2,290	186,914	26,710
VIRGIN ISLANDS	32,818	39	4,781	489	106	-	-	1,986	24,012	1,405
REGION III										
DELAWARE	21,816	920	3,562	960	234	439	226	-	15,388	87
DIST. OF COL.	66,372	3,516	8,554	1,975	2,396	1,165	221	19,032	23,024	6,488
MARYLAND	318,295	9,317	30,807	7,310	5,346	1,479	7,314	53,105	185,390	18,226
PENNSYLVANIA	114,111	2,087	72,724	12,212	8,190	1,090	11,352	-	5,655	802
VIRGINIA	83,750	8,883	47,419	6,178	3,659	4,139	551	-	-	12,920
WEST VIRGINIA	87,364	487	18,118	-	952	646	631	19,077	47,454	-
REGION IV										
ALABAMA	39,583	976	32,728	-	4,225	551	1,103	-	-	-
FLORIDA	101,954	3,372	67,921	-	12,038	3,225	7,255	258	4,831	3,054
GEORGIA	71,378	1,474	45,855	6,826	2,495	849	6,751	-	-	7,129
KENTUCKY	131,925	1,498	34,974	6,140	3,236	774	1,330	15,853	63,120	-
MISSISSIPPI	50,783	5,060	34,678	3,013	4,620	363	3,048	-	-	1
NORTH CAROLINA	107,902	2,187	69,994	9,197	2,588	2,288	4,919	-	7,438	9,292
SOUTH CAROLINA	70,560	11,102	41,744	4,442	1,991	308	6,409	-	4,441	122
TENNESSEE	81,736	4,808	52,913	7,148	6,906	2,514	2,172	-	-	5,275
REGION V										
ILLINOIS	58,717	91	48,266	-	1,725	494	3,307	-	-	4,834
INDIANA	23,225	2,510	16,562	-	1,156	622	2,078	-	-	297
MICHIGAN	141,601	292	57,093	22,955	4,325	520	2,763	31,765	11,446	10,441
MINNESOTA	22,526	1,160	15,417	4,559	937	83	371	-	-	-
OHIO	88,146	2,616	56,622	10,941	4,612	-	1,370	9,868	-	2,115
WISCONSIN	29,354	120	23,181	-	1,272	-	1,540	47	-	3,194
REGION VI										
ARKANSAS	24,555	2,043	18,683	-	2,950	268	563	48	-	-
LOUISIANA	64,960	1,378	49,031	7,205	5,302	97	1,395	142	-	411
NEW MEXICO	78,385	223	10,448	3,068	2,501	696	1,180	22,566	37,704	-
OKLAHOMA	34,969	1,175	22,233	-	2,244	336	2,516	5,749	-	716
TEXAS	138,824	5,806	61,534	23,635	12,389	1,414	16,450	-	10,217	7,377
REGION VII										
IOWA	19,501	3,663	13,188	-	1,044	424	984	-	-	198
KANSAS	15,297	1,597	9,669	2,124	826	71	440	-	-	571
MISSOURI	57,747	793	26,716	7,794	2,092	533	2,127	13	17,680	-
NEBRASKA	11,665	1,290	8,118	-	669	202	862	335	-	188
REGION VIII										
COLORADO	38,006	-	17,411	4,770	1,559	682	689	12,161	-	735
MONTANA	10,384	213	8,888	642	289	101	251	-	-	-
NORTH DAKOTA	22,576	799	4,291	-	382	71	115	1,442	15,475	-
SOUTH DAKOTA	10,432	2,802	4,689	828	666	28	96	1,322	-	-
UTAH	17,167	296	11,568	1,775	595	177	731	59	-	1,967
WYOMING	6,944	2,297	1,414	1,712	236	588	483	-	-	213
REGION IX										
ARIZONA	84,932	1,956	25,758	208	2,296	303	514	22,395	29,271	2,232
CALIFORNIA	185,890	1,103	116,678	43,240	8,763	2,130	5,567	-	-	8,409
HAWAII	109,670	3,827	10,366	1,544	1,884	720	701	18,178	71,808	642
NEVADA	10,215	721	5,645	2,669	653	402	106	-	-	19
AMERICAN SAMOA	6,934	276	244	69	126	250	52	18	5,868	31
GUAM*	-	-	-	-	-	-	-	-	-	-
NO. MARIANA IS.*	-	-	-	-	-	-	-	-	-	-
TRUST TERRITORY	8,530	27	481	109	83	503	44	85	7,198	-
REGION X										
ALASKA	14,321	6,863	3,334	1,655	1,602	21	-	-	-	846
IDAHO	13,689	314	7,199	1,547	798	223	510	3,099	-	-
OREGON	18,607	899	15,676	-	980	156	199	-	-	697
WASHINGTON	32,814	416	21,919	4,354	1,829	539	1,647	-	-	2,109

* THE PUBLIC HEALTH AGENCIES IN GUAM AND THE NORTHERN MARIANA ISLANDS DID NOT REPORT TO ASTHO/RS FOR FY 1981.

NOTE: THE DATA IN THIS TABLE RELATE ONLY TO EXPENDITURES OF OFFICIAL STATE HEALTH AGENCIES. THE PUBLIC HEALTH EXPENDITURES OF OTHER STATE AGENCIES SUCH AS SEPARATE MENTAL HEALTH AUTHORITIES, ENVIRONMENTAL AGENCIES, AND HOSPITAL AUTHORITIES ARE NOT REFLECTED IN THE ASTHO/RS DATA BASE.

1982

APPENDIX TABLE 8. HEALTH RESOURCES AND SERVICES ADMINISTRATION GRANT AND CONTRACT FUNDS EXPENDED FOR PUBLIC HEALTH PROGRAMS OF STATE HEALTH AGENCIES, BY AUTHORIZING STATUTE, FISCAL YEAR 1982

STATES AND TERRITORIES (1)	TOTAL HRSA GRANTS & CONTRACTS 1/ (2)	MATERNAL & CHILD HEALTH BLOCK GRANT (PL 97-35) (3)	MATERNAL & CHILD HEALTH (TITLE V, SSA) (4)	CRIPPLED CHILDREN (TITLE V, SSA) (5)	SERVICES FOR BLIND AND DISABLED CHILDREN (SSI, SEC. 1615(b), SSA) (6)	LEAD-BASED PAINT POISONING PREVENTION (SEC. 316, PHS ACT) (7)	GENETIC DISEASE (SEC. 1101, PHS ACT) (8)	FAMILY PLANNING (TITLE X, PHS ACT) (9)	MIGRANT HEALTH (SEC. 329, PHS ACT) (10)	NATIONAL HEALTH PLANNING & RESOURCES DEVELOPMENT ACT (PL 93-641) (11)	OTHER HRSA (12)
		*	*				(thousands of dollars)				
TOTAL	$386,635	$144,388	$83,218	$33,221	$5,912	$1,050	$6,197	$76,451	$2,906	$17,595	$15,696
REGION I											
CONNECTICUT	3,952	1,579	1,052	366	226	-	259	-	-	322	147
MAINE*	-	-	-	-	-	-	-	-	-	-	-
MASSACHUSETTS	5,719	4,965	535	-	-	-	210	-	-	-	-
NEW HAMPSHIRE	2,031	380	568	226	123	-	80	386	-	250	18
RHODE ISLAND	2,582	617	158	438	19	121	51	303	-	748	126
VERMONT	1,963	612	209	99	16	-	71	505	-	364	86
REGION II											
NEW JERSEY	10,721	2,954	966	1,135	236	-	547	2,971	-	725	1,189
NEW YORK	21,635	-	10,228	5,881	-	-	-	3,481	-	2,041	4
PUERTO RICO	9,280	468	2,218	816	121	-	-	460	1,125	-	4,072
VIRGIN ISLANDS	1,874	770	-	-	-	-	-	211	-	116	778
REGION III											
DELAWARE	1,553	552	192	123	-	107	-	580	-	-	-
DIST. OF COL.	7,214	5,623	653	38	-	2	-	-	-	694	213
MARYLAND	10,458	3,649	1,135	1,737	565	-	440	2,492	-	379	41
PENNSYLVANIA	20,444	10,710	3,609	1,580	1,182	-	483	-	295	1,375	1,210
VIRGINIA	11,548	4,340	2,145	825	35	-	450	3,204	-	549	-
WEST VIRGINIA	5,579	2,015	296	-	-	-	-	1,440	-	381	1,446
REGION IV											
ALABAMA	8,531	3,250	1,051	-	-	-	-	4,135	-	-	94
FLORIDA	11,851	4,053	2,041	-	-	-	-	5,499	167	-	90
GEORGIA	15,890	7,136	2,760	745	333	-	-	4,888	-	-	29
KENTUCKY	10,953	3,213	2,229	1,486	-	-	126	3,452	-	395	52
MISSISSIPPI	9,117	2,860	2,147	861	-	-	-	3,159	-	-	90
NORTH CAROLINA	14,956	5,980	2,110	1,010	557	-	257	4,701	149	-	192
SOUTH CAROLINA	13,461	3,531	2,362	891	213	440	-	4,179	29	423	1,393
TENNESSEE	13,906	4,295	2,502	1,133	-	-	409	4,807	-	-	760
REGION V											
ILLINOIS	11,357	5,310	4,588	-	-	258	-	-	-	1,173	28
INDIANA	5,009	3,483	716	-	-	-	175	-	-	571	64
MICHIGAN	15,825	8,837	1,654	270	-	-	163	4,847	-	-	55
MINNESOTA	6,280	3,143	1,615	888	264	-	177	-	-	95	98
OHIO	16,647	6,990	2,932	1,573	298	-	256	3,021	-	587	590
WISCONSIN*	-	-	-	-	-	-	-	-	-	-	-
REGION VI											
ARKANSAS	4,229	1,584	1,067	-	-	121	-	1,168	-	-	289
LOUISIANA	9,904	4,640	1,645	564	150	-	300	2,500	-	-	86
NEW MEXICO	2,687	1,477	453	208	-	-	-	181	-	417	-
OKLAHOMA	4,675	1,388	850	-	-	-	34	2,256	81	-	66
TEXAS	14,676	11,274	1,700	42	115	-	550	-	70	926	-
REGION VII											
IOWA	4,042	1,554	884	-	-	-	75	1,168	-	321	40
KANSAS	4,728	1,866	587	238	193	-	-	1,289	173	382	-
MISSOURI	7,448	3,878	1,460	1,110	278	-	169	-	-	-	553
NEBRASKA	3,593	861	1,033	-	-	-	106	1,052	159	330	52
REGION VIII											
COLORADO	7,286	2,985	411	967	359	-	328	1,123	659	307	147
MONTANA*	-	-	-	-	-	-	-	-	-	-	-
NORTH DAKOTA	1,931	445	527	-	-	-	-	586	-	354	-
SOUTH DAKOTA	2,654	966	276	145	77	-	-	466	-	292	462
UTAH	4,456	1,210	1,799	659	42	-	124	272	-	276	74
WYOMING	1,423	514	187	510	7	-	-	-	-	204	-
REGION IX											
ARIZONA	4,709	1,846	1,770	350	262	-	-	-	-	481	-
CALIFORNIA	13,483	-	8,333	4,705	-	-	-	-	-	-	445
HAWAII	3,229	800	795	155	47	-	44	1,010	-	639	237
NEVADA	1,652	747	638	-	30	-	-	175	-	63	-
AMERICAN SAMOA*	-	-	-	-	-	-	-	-	-	-	-
GUAM*	-	-	-	-	-	-	-	-	-	-	-
NO. MARIANA IS.*	-	-	-	-	-	-	-	-	-	-	-
TRUST TERRITORY	1,501	-	485	313	-	-	-	68	-	284	352
REGION X											
ALASKA	1,116	401	525	190	-	-	-	-	-	-	-
IDAHO	3,661	1,258	762	350	51	-	52	786	-	377	25
OREGON	3,930	1,778	610	-	-	-	-	1,542	-	-	-
WASHINGTON	8,787	1,539	3,832	603	114	-	252	2,090	-	356	-

1/ THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981 (PL 97-35) CREATED SEVERAL BLOCK GRANT FUNDING MECHANISMS EFFECTIVE AT THE BEGINNING OF THE FEDERAL FISCAL YEAR 1982 (OCTOBER 1, 1981). HOWEVER, SINCE MOST STATES USE A JULY-JUNE FISCAL YEAR, THERE IS A COMBINATION OF BLOCK GRANT FUNDS AND FUNDS FROM THE FORMER CATEGORICAL GRANTS REPORTED IN THIS TABLE. GRANTS THAT WERE ADMINISTERED BY ONE FEDERAL AGENCY AS CATEGORICAL FUNDS AND TRANSFERRED TO ANOTHER FEDERAL AGENCY AS PART OF THE BLOCK GRANT ARE REPORTED ABOVE UNDER THE AGENCY THAT ADMINISTERED THEM AS PART OF THE BLOCK GRANTS. FOR EXAMPLE, 317(A) HYPERTENSION FUNDS ARE INCLUDED IN APPENDIX TABLE 9, CENTERS FOR DISEASE CONTROL (WHICH ADMINISTERS THE PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT), NOT APPENDIX TABLE 8, HEALTH RESOURCES AND SERVICES ADMINISTRATION.

* THE PUBLIC HEALTH AGENCIES IN AMERICAN SAMOA, GUAM, MAINE, MONTANA, THE NORTHERN MARIANA ISLANDS, AND WISCONSIN DID NOT REPORT TO THE ASTHO FOUNDATION FOR FY 1982.

NOTE: THE DATA IN THIS TABLE RELATE ONLY TO EXPENDITURES OF OFFICIAL STATE HEALTH AGENCIES. THE PUBLIC HEALTH EXPENDITURES OF OTHER AGENCIES SUCH AS SEPARATE MENTAL HEALTH AUTHORITIES, ENVIRONMENTAL AGENCIES, AND HOSPITAL AUTHORITIES ARE NOT REFLECTED IN THE ASTHO FOUNDATION'S DATA BASE.

SOURCE: ASTHO FOUNDATION, 10400 CONNECTICUT AVENUE, KENSINGTON, MD 20895.

1982

APPENDIX TABLE 12. PERSONAL HEALTH PROGRAM EXPENDITURES OF STATE HEALTH AGENCIES, BY PROGRAM CATEGORY, FISCAL YEAR 1982

STATES AND TERRITORIES (1)	TOTAL PERSONAL HEALTH (2)	SUPPORTING PERSONAL HEALTH SERVICES (3)	MATERNAL AND CHILD HEALTH (4)	HANDICAPPED CHILDREN'S SERVICES (5)	COMMUNICABLE DISEASE CONTROL (6)	DENTAL HEALTH (7)	CHRONIC DISEASE (8)	MENTAL HEALTH, ALCOHOL AND DRUG ABUSE (9)	STATE-OPERATED INSTITUTIONS (10)	OTHER PERSONAL HEALTH (11)
					(thousands of dollars)					
TOTAL	$3,682,062	$120,979	$1,495,083	$228,632	$146,884	$37,378	$189,129	$278,522	$936,563	$248,893
REGION I										
CONNECTICUT	32,178	1,379	19,284	1,963	1,568	-	881	-	5,103	2,000
MAINE*	-	-	-	-	-	-	-	-	-	-
MASSACHUSETTS	111,784	110	18,888	4,673	5,213	248	950	21,687	58,160	1,855
NEW HAMPSHIRE	8,461	426	5,827	1,155	327	258	450	18	-	-
RHODE ISLAND	14,038	750	7,848	576	584	285	926	-	-	2,719
VERMONT	11,931	308	8,298	841	540	751	158	-	-	1,033
REGION II										
NEW JERSEY	74,120	-	26,582	4,298	3,988	227	2,974	23,319	-	12,732
NEW YORK	259,294	837	85,967	1,250	2,943	671	13,418	-	92,038	62,170
PUERTO RICO	270,488	-	44,511	2,207	4,211	537	1,879	11,062	168,425	37,657
VIRGIN ISLANDS	35,738	110	5,370	252	88	-	138	1,894	26,987	899
REGION III										
DELAWARE	23,065	516	4,356	1,071	277	565	456	-	15,552	272
DIST. OF COL.	73,300	3,486	8,495	1,697	2,473	1,648	118	25,331	23,882	6,171
MARYLAND	329,922	9,819	30,466	7,392	4,543	1,506	36,816	33,463	187,113	18,803
PENNSYLVANIA	155,635	1,164	66,152	12,541	6,975	186	11,753	36,853	6,777	13,234
VIRGINIA	90,159	10,536	51,765	4,768	3,748	4,667	922	-	-	13,753
WEST VIRGINIA	96,280	710	16,831	-	986	752	21,302	2,984	52,716	-
REGION IV										
ALABAMA	35,627	1,082	28,849	-	4,299	575	822	-	-	-
FLORIDA	109,767	4,086	72,335	-	12,540	3,454	9,297	-	5,094	2,961
GEORGIA	77,587	2,503	50,678	7,030	2,570	982	5,969	-	-	7,855
KENTUCKY	140,808	1,670	36,860	6,889	3,173	728	2,618	16,953	71,918	-
MISSISSIPPI	56,794	5,624	39,093	2,757	5,976	618	2,724	-	-	-
NORTH CAROLINA	106,943	3,655	68,908	8,197	3,440	2,253	5,562	-	6,705	8,223
SOUTH CAROLINA	81,862	13,496	49,796	5,334	2,365	296	6,312	-	3,415	848
TENNESSEE	79,605	4,977	48,857	7,545	6,882	3,720	2,013	-	-	5,6
REGION V										
ILLINOIS	53,058	176	43,729	-	1,316	484	2,832	-	-	4,522
INDIANA	23,867	1,999	17,532	-	1,121	1,251	1,697	-	-	267
MICHIGAN	143,551	249	55,130	21,463	4,404	336	3,186	32,896	12,850	13,037
MINNESOTA	26,910	1,328	19,761	4,231	1,076	74	440	-	-	-
OHIO	76,288	2,420	51,695	6,057	3,665	-	1,894	8,654	-	1,903
WISCONSIN*	-	-	-	-	-	-	-	-	-	-
REGION VI										
ARKANSAS	28,850	3,522	20,922	-	3,725	47	551	39	-	44
LOUISIANA	73,497	2,059	51,731	9,866	6,926	344	1,957	-	-	616
NEW MEXICO	62,173	648	9,055	2,072	1,732	636	783	1,722	45,515	9
OKLAHOMA	38,785	1,580	22,896	-	2,555	396	3,307	7,216	-	836
TEXAS	153,218	7,281	67,693	23,725	14,251	1,815	17,964	-	12,989	7,500
REGION VII										
IOWA	20,397	3,918	14,027	-	814	378	1,068	-	-	192
KANSAS	15,339	1,512	10,292	2,042	815	64	391	-	-	224
MISSOURI	57,252	1,416	28,012	6,997	1,974	637	1,700	20	16,471	25
NEBRASKA	10,647	1,220	7,065	-	650	195	1,335	-	-	182
REGION VIII										
COLORADO	36,664	-	16,389	4,504	1,651	680	734	11,986	-	720
MONTANA*	-	-	-	-	-	-	-	-	-	-
NORTH DAKOTA	6,827	24	5,546	-	454	96	118	371	-	-
SOUTH DAKOTA	9,837	3,218	4,071	787	572	23	13	1,153	-	-
UTAH	14,784	469	8,549	1,913	626	191	881	74	-	2,082
WYOMING	8,878	2,668	2,624	2,251	191	349	558	-	-	237
REGION IX										
ARIZONA	85,036	2,576	19,806	-	2,276	359	624	23,980	32,040	3,373
CALIFORNIA	232,991	1,125	157,859	47,059	7,685	1,550	8,867	-	-	8,845
HAWAII	123,626	4,426	10,184	1,248	2,123	802	6,676	14,590	82,976	601
NEVADA	10,930	640	6,001	3,153	599	400	109	-	-	27
AMERICAN SAMOA*	-	-	-	-	-	-	-	-	-	-
GUAM*	-	-	-	-	-	-	-	-	-	-
NO. MARIANA IS.*	-	-	-	-	-	-	-	-	-	-
TRUST TERRITORY	11,512	39	552	313	31	673	61	5	9,836	-
REGION X										
ALASKA	17,155	7,521	4,978	1,842	1,821	54	-	-	-	939
IDAHO	12,183	380	6,774	1,358	742	186	491	2,253	-	-
OREGON	17,111	457	13,464	-	1,167	98	213	-	-	1,712
WASHINGTON	35,259	645	22,731	5,315	1,815	331	2,220	-	-	2,201

* THE PUBLIC HEALTH AGENCIES IN AMERICAN SAMOA, GUAM, MAINE, MONTANA, THE NORTHERN MARIANA ISLANDS, AND WISCONSIN DID NOT REPORT TO THE ASTHO FOUNDATION FOR FY 1982.

NOTE. THE DATA IN THIS TABLE RELATE ONLY TO EXPENDITURES OF OFFICIAL STATE HEALTH AGENCIES. THE PUBLIC HEALTH EXPENDITURES OF OTHER AGENCIES SUCH AS SEPARATE MENTAL HEALTH AUTHORITIES, ENVIRONMENTAL AGENCIES, AND HOSPITAL AUTHORITIES ARE NOT REFLECTED IN THE ASTHO FOUNDATION'S DATA BASE.

SOURCE: ASTHO FOUNDATION, 10400 CONNECTICUT AVENUE, KENSINGTON, MD 20895.

1983

APPENDIX TABLE 8. HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) GRANT AND CONTRACT FUNDS EXPENDED FOR PUBLIC HEALTH PROGRAMS OF STATE HEALTH AGENCIES, BY AUTHORIZING STATUTE, FISCAL YEAR 1983

STATES AND TERRITORIES (1)	TOTAL HRSA GRANT AND CONTRACT FUNDS (2)	MATERNAL & CHILD HEALTH BLOCK GRANT (PL 97-35) 1/ (3)	MATERNAL & CHILD HEALTH (TITLE V, SSA) (4)	CRIPPLED CHILDREN (TITLE V, SSA) (5)	SERVICES FOR BLIND AND DISABLED CHILDREN (SSI, SEC. 1615(a), SSA) (6)	LEAD-BASED PAINT POISONING PREVENTION (SEC. 316, PHSA) (7)	GENETIC DISEASE (SEC. 1101, PHSA) (8)	FAMILY PLANNING (TITLE X, PHSA) (9)	MIGRANT HEALTH (SEC. 329, PHSA) (10)	NATIONAL HEALTH PLANNING & RESOURCES DEVELOPMENT ACT (PL 93-641) (11)	OTHER HRSA (12)
					(thousands of dollars)						
TOTAL	$398,211	$267,320	$16,093	$7,942	$1,033	$376	$5,521	$68,202	$3,655	$14,009	$14,061
ALABAMA	11,546	7,984	362	-	-	-	-	3,174	-	-	26
ALASKA	923	607	245	-	-	-	-	-	-	-	70
ARIZONA	3,209	2,504	498	2	6	-	-	-	-	200	-
ARKANSAS	3,850	2,146	-	-	-	-	-	1,575	-	-	129
CALIFORNIA	18,393	17,775	-	430	-	-	-	-	-	-	187
COLORADO	8,710	4,228	-	333	-	-	822	959	755	233	1,381
CONNECTICUT	3,585	2,553	459	-	39	110	135	-	-	267	21
DELAWARE	1,771	1,323	12	3	-	#	-	433	-	-	-
DIST. OF COL.	5,948	5,467	-	-	-	-	273	-	-	-	208
FLORIDA	15,706	10,957	-	-	-	-	-	4,436	312	-	-
GEORGIA	13,796	10,325	20	-	-	-	-	3,437	-	-	14
HAWAII	2,810	1,288	150	18	-	-	70	771	-	442	71
IDAHO	2,686	1,845	14	-	-	-	43	501	-	269	13
ILLINOIS	6,025	5,023	73	-	-	41	-	-	-	875	13
INDIANA	4,469	3,599	308	-	-	-	188	-	-	373	-
IOWA	2,963	1,932	-	-	-	-	46	781	-	203	-
KANSAS	4,539	3,134	-	-	-	-	-	956	99	351	-
KENTUCKY	10,228	6,705	419	-	-	42	248	2,542	-	260	12
LOUISIANA	10,580	7,555	263	-	-	-	366	2,279	-	-	118
MAINE*	-	-	-	-	-	-	-	-	-	-	-
MARYLAND	12,485	8,045	782	649	-	-	-	2,096	-	273	640
MASSACHUSETTS	8,079	7,634	169	-	-	-	277	-	-	-	-
MICHIGAN	17,576	12,419	-	-	-	-	-	5,084	-	-	74
MINNESOTA	5,545	5,186	4	88	-	-	163	-	-	79	25
MISSISSIPPI	8,582	5,693	476	-	-	-	-	2,391	-	-	21
MISSOURI	8,371	7,828	-	-	-	-	366	-	-	177	-
MONTANA*	-	-	-	-	-	-	-	-	-	-	-
NEBRASKA	2,912	1,638	55	-	-	-	75	787	132	204	20
NEVADA	1,790	838	663	-	-	-	-	198	-	91	-
NEW HAMPSHIRE	2,532	1,473	-	134	-	-	106	469	-	338	13
NEW JERSEY	11,036	6,843	-	-	-	-	539	1,881	-	657	1,117
NEW MEXICO*	-	-	-	-	-	-	-	-	-	-	-
NEW YORK	28,247	11,605	7,833	3,087	-	-	-	3,851	-	1,648	224
NORTH CAROLINA	14,144	9,423	253	-	2	-	315	3,851	189	-	113
NORTH DAKOTA	1,214	131	315	-	-	-	-	447	-	321	-
OHIO	15,720	11,548	-	-	-	-	-	2,995	-	710	467
OKLAHOMA	3,759	1,829	-	-	-	-	56	1,500	107	-	267
OREGON	4,299	3,191	14	-	-	-	-	996	-	-	-
PENNSYLVANIA	18,677	14,238	471	580	862	-	300	-	512	619	1,097
RHODE ISLAND	1,969	1,120	9	-	-	-	124	275	-	421	20
SOUTH CAROLINA	10,429	4,761	179	2,027	-	84	248	2,669	22	315	124
SOUTH DAKOTA*	-	-	-	-	-	-	-	-	-	-	-
TENNESSEE	8,815	4,769	-	-	-	-	249	2,846	-	-	951
TEXAS	23,277	14,165	508	51	-	-	311	7,457	40	745	-
UTAH	5,212	4,088	223	-	-	-	-	493	-	372	38
VERMONT	1,808	1,100	-	-	-	-	27	330	-	345	5
VIRGINIA	9,724	5,861	458	245	-	-	173	2,443	-	545	-
WASHINGTON	9,185	6,177	474	-	-	-	-	2,063	-	274	297
WEST VIRGINIA	6,500	3,510	86	-	-	-	-	920	-	380	1,603
WISCONSIN	5,119	4,629	-	-	-	98	-	-	-	364	27
WYOMING	1,439	676	297	298	#	-	-	-	-	168	-
AMERICAN SAMOA	464	206	-	-	-	-	-	42	-	217	-
GUAM*	-	-	-	-	-	-	-	-	-	-	-
NO. MARIANA IS.*	-	-	-	-	-	-	-	-	-	-	-
PUERTO RICO	16,229	9,188	-	-	125	-	-	200	1,487	1,191	4,038
TRUST TERRITORY*	-	-	-	-	-	-	-	-	-	-	-
VIRGIN ISLANDS	1,332	563	-	-	-	-	-	73	-	81	616

1/ THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981 (PL 97-35) CREATED SEVERAL BLOCK GRANT FUNDING MECHANISMS EFFECTIVE AT THE BEGINNING OF THE FEDERAL FISCAL YEAR 1982 (OCTOBER 1, 1981). HOWEVER, SINCE MOST STATES USE A JULY-JUNE FISCAL YEAR, THERE IS A COMBINATION OF BLOCK GRANT FUNDS AND FUNDS FROM THE FORMER CATEGORICAL GRANTS REPORTED IN THIS TABLE. GRANTS THAT WERE ADMINISTERED BY ONE FEDERAL AGENCY AS CATEGORICAL FUNDS AND TRANSFERRED TO ANOTHER FEDERAL AGENCY AS PART OF THE BLOCK GRANT ARE REPORTED ABOVE UNDER THE AGENCY THAT ADMINISTERED THEM AS PART OF THE BLOCK GRANTS.

* THE PUBLIC HEALTH AGENCIES IN GUAM, MAINE, MONTANA, NEW MEXICO, THE NORTHERN MARIANA ISLANDS, SOUTH DAKOTA, AND THE TRUST TERRITORY DID NOT REPORT TO THE ASTHO FOUNDATION FOR FY 1983.

NOTE: THE DATA IN THIS TABLE RELATE ONLY TO EXPENDITURES OF OFFICIAL STATE HEALTH AGENCIES. THE PUBLIC HEALTH EXPENDITURES OF OTHER AGENCIES SUCH AS SEPARATE MENTAL HEALTH AUTHORITIES, ENVIRONMENTAL AGENCIES, AND HOSPITAL AUTHORITIES ARE NOT REFLECTED IN THE ASTHO FOUNDATION'S DATA BASE.

STANDARD SYMBOLS: - = ZERO OR NO DATA; # = LESS THAN 0.05 PERCENT OR LESS THAN $500; E = ESTIMATED BY THE RESPONDENT, U = DATA REPORTED AS UNOBTAINABLE BY THE RESPONDENT; C = DATA FOR THIS ITEM WAS COMBINED WITH REPORTING OF ANOTHER ITEM.

SOURCE: ASTHO FOUNDATION, 10400 CONNECTICUT AVENUE, KENSINGTON, MARYLAND 20895.

1983

APPENDIX TABLE 12. PERSONAL HEALTH PROGRAM EXPENDITURES OF STATE HEALTH AGENCIES, BY PROGRAM CATEGORY, FISCAL YEAR 1983

STATES AND TERRITORIES (1)	TOTAL PERSONAL HEALTH (2)	SUPPORTING PERSONAL HEALTH SERVICES (3)	MATERNAL AND CHILD HEALTH (4)	HANDICAPPED CHILDREN'S SERVICES (5)	COMMUNICABLE DISEASE CONTROL (6)	DENTAL HEALTH (7)	CHRONIC DISEASE (8)	MENTAL HEALTH (9)	ALCOHOL & DRUG ABUSE (10)	SHA-OPERATED INSTI-TUTIONS (11)	OTHER PERSONAL HEALTH (12)
					(thousands of dollars)						
TOTAL	$3,988,005	$165,405	$1,700,067	$247,572	$145,475	$40,112	$205,760	$101,034	$210,637	$936,154	$235,790
ALABAMA	41,529	978	35,337	-	4,123	362	672	-	-	-	57
ALASKA	19,232	8,973	5,123	2,030	2,167	-	-	-	-	-	939
ARIZONA	83,562	2,002	17,949	-	1,909	397	383	13,110	14,495	29,557	3,759
ARKANSAS	31,598	5,968	20,230	-	4,217	419	672	13	-	-	79
CALIFORNIA	293,957	1,556	195,060	47,947	9,055	1,946	12,809	-	-	-	25,584
COLORADO	41,777	-	17,490	3,488	1,428	750	675	-	15,374	-	2,572
CONNECTICUT	33,091	1,467	19,907	2,003	1,688	-	1,417	-	-	5,527	1,083
DELAWARE	25,547	633	4,692	1,014	254	560	361	-	-	16,673	1,359
DIST. OF COL.	71,288	12,522	10,236	1,246	2,484	1,495	195	11,531	8,253	19,348	3,977
FLORIDA	130,742	2,950	81,095	-	12,568	3,850	23,485	-	-	6,793	-
GEORGIA	77,548	1,916	52,442	6,456	2,512	1,192	5,185	-	-	-	7,845
HAWAII	137,564	4,779	10,665	1,388	2,303	839	6,497	12,244	2,825	95,684	340
IDAHO	13,713	327	7,835	1,127	646	201	527	-	3,050	-	-
ILLINOIS	60,159	44	51,200	-	1,300	413	2,702	-	-	-	4,531
INDIANA	20,737	1,369	16,193	-	880	934	1,131	-	-	-	230
IOWA	25,713	9,403	14,029	-	704	244	1,132	-	-	-	200
KANSAS	15,611	941	10,829	2,107	916	95	540	-	-	-	183
KENTUCKY	156,855	1,482	39,325	7,691	2,338	796	3,275	23,028	3,697	75,222	-
LOUISIANA	84,076	2,348	59,659	11,161	7,557	265	2,454	-	-	-	633
MAINE*	-	-	-	-	-	-	-	-	-	-	-
MARYLAND	374,803	11,303	33,534	7,004	6,382	1,607	44,126	20,561	18,671	209,513	22,103
MASSACHUSETTS	138,770	414	25,617	8,037	6,131	2,196	691	-	33,631	58,965	3,098
MICHIGAN	155,622	941	64,243	22,969	4,483	257	2,345	-	34,308	14,371	11,702
MINNESOTA	28,075	1,124	21,977	3,468	955	36	516	-	-	-	-
MISSISSIPPI	61,351	7,104	41,980	3,586	5,911	613	2,156	-	-	-	-
MISSOURI	55,018	978	31,497	7,710	1,822	562	1,719	9	-	10,626	95
MONTANA*	-	-	-	-	-	-	-	-	-	-	-
NEBRASKA	11,492	1,535	7,327	-	584	198	1,666	-	-	-	182
NEVADA	11,095	665	6,182	3,095	652	355	122	-	-	-	23
NEW HAMPSHIRE	9,940	829	7,077	1,275	357	237	153	13	-	-	-
NEW JERSEY	68,765	-	29,688	4,601	3,540	232	3,651	-	21,134	-	5,921
NEW MEXICO*	-	-	-	-	-	-	-	-	-	-	-
NEW YORK	283,319	2,113	107,460	1,327	2,639	1,404	9,372	-	-	102,277	56,726
NORTH CAROLINA	109,458	3,718	70,764	9,011	3,581	2,390	5,381	-	-	6,640	7,973
NORTH DAKOTA	6,809	268	5,992	-	370	97	82	-	-	-	-
OHIO	91,297	2,660	53,933	15,339	3,139	370	1,358	-	12,502	-	1,986
OKLAHOMA	47,637	1,299	26,544	-	2,696	491	1,561	10,328	-	-	4,717
OREGON	19,056	458	15,864	-	1,098	80	149	-	-	-	1,406
PENNSYLVANIA	165,401	810	73,437	13,276	7,289	138	12,203	-	39,633	4,420	14,195
RHODE ISLAND	14,267	683	8,836	477	786	185	386	-	-	-	2,913
SOUTH CAROLINA	81,483	15,803	48,241	5,478	2,530	287	5,533	-	-	2,091	1,521
SOUTH DAKOTA*	-	-	-	-	-	-	-	-	-	-	-
TENNESSEE	82,910	2,792	53,259	5,989	6,560	3,721	2,764	-	-	-	7,823
TEXAS	182,128	8,234	87,067	30,122	14,821	1,736	16,774	-	-	13, 34	9,541
UTAH	19,069	789	12,318	1,890	744	215	843	83	-	-	2,185
VERMONT	12,869	544	9,873	983	574	771	124	-	-	-	-
VIRGINIA	95,932	11,319	55,537	5,742	2,760	4,974	795	-	-	-	14,805
WASHINGTON	33,491	315	24,956	4,209	1,435	209	686	-	-	-	1,681
WEST VIRGINIA	95,105	602	18,39-	1,146	837	629	21,580	64	2,372	49,481	-
WISCONSIN	34,164	74	26,161	-	640	37	2,028	27	-	-	5,196
WYOMING	10,209	2,645	3,209	2,796	215	648	573	-	-	-	123
AMERICAN SAMOA	7,055	347	383	-	114	289	200	39	-	5,650	34
GUAM*	-	-	-	-	-	-	-	-	-	-	-
NO. MARIANA IS.*	-	-	-	-	-	-	-	-	-	-	-
PUERTO RICO	274,828	25,379	54,159	304	2,702	386	2,069	9,662	-	174,642	5,525
TRUST TERRITORY*	-	-	-	-	-	-	-	-	-	-	-
VIRGIN ISLANDS	42,291	-	5,261	82	82	-	31	323	692	34,848	972

* THE PUBLIC HEALTH AGENCIES IN GUAM, MAINE, MONTANA, NEW MEXICO, THE NORTHERN MARIANA ISLANDS, SOUTH DAKOTA, AND THE TRUST TERRITORY DID NOT REPORT TO THE ASTHO FOUNDATION FOR FY 1983.

NOTE: THE DATA IN THIS TABLE RELATE ONLY TO EXPENDITURES OF OFFICIAL STATE HEALTH AGENCIES. THE PUBLIC HEALTH EXPENDITURES OF OTHER AGENCIES SUCH AS SEPARATE MENTAL HEALTH AUTHORITIES, ENVIRONMENTAL AGENCIES, AND HOSPITAL AUTHORITIES ARE NOT REFLECTED IN THE ASTHO FOUNDATION'S DATA BASE.

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SOURCE: ASTHO FOUNDATION 10400 CONNECTICUT AVENUE, KENSINGTON, MARYLAND 20895.

1984

APPENDIX TABLE B. HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) GRANT AND CONTRACT FUNDS EXPENDED FOR PUBLIC HEALTH PROGRAMS OF STATE HEALTH AGENCIES, BY AUTHORIZING STATUTE, FISCAL YEAR 1984

STATES AND TERRITORIES (1)	TOTAL HRSA GRANT AND CONTRACT FUNDS 1/ (2)	MATERNAL & CHILD HEALTH BLOCK GRANT (PL 97-35) (3)	MATERNAL & CHILD HEALTH (TITLE V, SSA) (4)	CRIPPLED CHILDREN (TITLE V, SSA) (5)	SERVICES FOR BLIND AND DISABLED CHILDREN (SSI, SEC. 1615(B), SSA) (6)	LEAD-BASED PAINT POISONING PREVENTION (SEC. 316, PHSA) (7)	GENETIC DISEASE (SEC. 1101, PHSA) (8)	FAMILY PLANNING (TITLE X, PHSA) (9)	MIGRANT HEALTH (SEC. 329, PHSA) (10)	NATIONAL HEALTH PLANNING & RESOURCES DEVELOPMENT ACT (PL 93-641) (11)	OTHER HRSA (12)
		*	*		(THOUSANDS OF DOLLARS)						
TOTAL	$449,886	$336,382	$5,723	$2,136	$2**	$50	$4,616	$70,867	$4,350	$11,282	$14,190
ALABAMA	11,189	8,361	59	-	-	-	-	2,763	-	-	6
ALASKA	1,310	703	304	-	-	-	-	-	-	-	304
ARIZONA	3,165	2,472	527	-	-	-	-	-	-	167	-
ARKANSAS	5,043	3,135	-	-	-	-	-	1,908	-	-	-
CALIFORNIA	27,515	27,069	-	-	-	-	446	-	-	-	-
COLORADO	10,271	5,796	-	343	-	-	755	963	853	193	1,368
CONNECTICUT	4,527	3,674	535	47	18	-	34	-	-	258	8
DELAWARE	1,885	1,395	-	-	-	-	-	490	-	-	-
DIST. OF COL.	6,251	5,985	-	-	-	-	256	-	-	-	9
FLORIDA	13,769	9,425	-	-	-	-	-	3,913	92	-	339
GEORGIA	18,063	14,650	-	-	-	-	-	3,413	-	-	-
HAWAII	3,523	1,616	234	-	-	-	62	884	-	668	257
IDAHO	3,739	2,815	-	-	-	-	314	591	-	220	-
ILLINOIS	15,830	10,971	-	-	-	-	-	3,879	-	735	245
INDIANA	6,521	5,715	-	-	-	-	240	-	-	385	182
IOWA	3,847	2,889	-	-	-	-	18	687	-	254	-
KANSAS	3,387	3,060	-	-	-	-	109	936	91	242	150
KENTUCKY	11,597	8,538	261	-	-	41	225	2,326	-	206	-
LOUISIANA	13,579	10,631	-	-	-	-	340	2,261	-	-	327
MAINE*	-	-	-	-	-	-	-	-	-	-	-
MARYLAND	13,712	10,272	1,104	30	-	-	-	2,080	-	225	-
MASSACHUSETTS*	-	-	-	-	-	-	-	-	-	-	-
MICHIGAN	17,877	13,727	-	-	-	-	-	4,045	-	-	106
MINNESOTA	6,250	5,958	-	-	-	-	164	-	-	128	-
MISSISSIPPI	11,030	7,505	1,011	130	-	-	-	2,385	-	-	-
MISSOURI	9,994	9,413	80	-	-	-	333	-	-	168	-
MONTANA*	-	-	-	-	-	-	-	-	-	-	-
NEBRASKA	3,497	2,137	-	-	-	-	40	899	201	198	23
NEVADA	1,589	1,005	-	-	-	-	-	167	-	192	225
NEW HAMPSHIRE	2,381	1,538	7	143	-	8	47	505	-	41	92
NEW JERSEY	13,811	9,976	-	-	-	-	27	2,013	-	477	1,317
NEW MEXICO*	-	-	-	-	-	-	-	-	-	-	-
NEW YORK	27,650	22,410	72	637	124	-	-	3,153	-	1,061	393
NORTH CAROLINA	17,746	13,083	-	-	-	-	296	3,724	516	-	127
NORTH DAKOTA	2,132	1,492	-	-	-	-	-	315	-	254	-
OHIO*	-	-	-	-	-	-	-	-	-	-	-
OKLAHOMA	6,734	4,128	167	-	-	-	172	2,116	151	-	-
OREGON	5,410	4,466	-	-	-	-	-	945	-	-	-
PENNSYLVANIA	21,633	19,007	-	648	-	-	45	-	528	361	1,044
RHODE ISLAND	2,289	1,345	77	-	-	-	6	270	-	581	-
SOUTH CAROLINA	12,911	9,431	-	-	-	-	456	2,554	276	-	195
SOUTH DAKOTA*	-	-	-	-	-	-	-	-	-	-	-
TENNESSEE	13,250	8,756	477	-	-	-	208	3,351	36	403	-
TEXAS	32,221	21,442	164	158	-	-	-	9,437	-	715	106
UTAH	5,450	5,014	92	-	-	-	-	344	-	-	-
VERMONT	2,001	1,319	-	-	-	-	6	394	-	282	-
VIRGINIA	13,809	10,435	134	-	-	-	196	2,361	-	383	-
WASHINGTON	8,609	5,794	326	-	-	-	-	2,369	-	11	110
WEST VIRGINIA	9,416	6,152	38	-	-	-	-	1,131	-	572	1,537
WISCONSIN*	-	-	-	-	-	-	-	-	-	-	-
WYOMING	637	403	51	0	-	-	-	-	-	182	-
AMERICAN SAMOA*	-	-	-	-	-	-	-	-	-	-	-
GUAM*	-	-	-	-	-	-	-	-	-	-	-
PUERTO RICO	19,692	9,926	-	-	149	-	-	586	1,606	1,796	5,629
VIRGIN ISLANDS	932	564	-	-	-	-	-	164	-	124	101

1/ THE OMNIBUS RECONCILIATION ACT OF 1982 (PL 97 35) CREATED SEVERAL BLOCK GRANT MECHANISMS EFFECTIVE AT THE BEGINNING OF THE FEDERAL FISCAL YEAR 1982 (OCTOBER 1, 1981) GRANTS THAT WERE ADMINISTERED BY ONE FEDERAL AGENCY AS CATEGORICAL FUNDS AND TRANSFERRED TO ANOTHER FEDERAL AGENCY AS PART OF THE BLOCK GRANT ARE REPORTED ABOVE UNDER THE AGENCY THAT ADMINISTERED THEM AS PART OF THE BLOCK GRANTS.

* THE PUBLIC HEALTH AGENCIES IN MAINE, MASSACHUSETTS, MONTANA, NEW MEXICO, OHIO, SOUTH DAKOTA, WISCONSIN, AMERICAN SAMOA, AND GUAM DID NOT REPORT TO THE PUBLIC HEALTH FOUNDATION FOR FY 1984.

NOTE: THE DATA IN THIS TABLE RELATE ONLY TO EXPENDITURES OF OFFICIAL STATE HEALTH AGENCIES THE PUBLIC HEALTH EXPENDITURES OF OTHER AGENCIES SUCH AS SEPARATE MENTAL HEALTH AUTHORITIES, ENVIRONMENTAL AGENCIES, AND HOSPITAL AUTHORITIES ARE NOT REFLECTED IN THE PUBLIC HEALTH FOUNDATION'S DATA BASE.

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SOURCE: PUBLIC HEALTH FOUNDATION, 1220 L STREET, N.W., SUITE 350, WASHINGTON, D.C. 20005.

227

1984

APPENDIX TABLE 12. PERSONAL HEALTH PROGRAM EXPENDITURES OF STATE HEALTH AGENCIES, BY PROGRAM CATEGORY, FISCAL YEAR 1984

STATES AND TERRITORIES (1)	TOTAL PERSONAL HEALTH (2)	SUPPORTING PERSONAL HEALTH SERVICES (3)	MATERNAL AND CHILD HEALTH (4)	HANDICAPPED CHILDREN'S SERVICES (5)	COMMUNICABLE DISEASE CONTROL (6)	DENTAL HEALTH (7)	CHRONIC DISEASE (8)	MENTAL HEALTH (9)	ALCOHOL & DRUG ABUSE (10)	A* STED INSTI- TUTIONS (11)	OTHER PERSONAL HEALTH (12)
					(THOUSANDS OF DOLLARS)						
TOTAL	$4,2[illegible],656	$224,352	$1,978,21[illegible]	$247,871	$160,165	$38,405	$215,674	$108,369	$170,845	$900,798	$251,968
ALABAMA	49,277	1,178	42,990	-	4,029	377	657	-	-	-	46
ALASKA	19,788	11,550	4,304	3,073	1,862	-	-	-	-	-	-
ARIZONA	83,361	2,032	19,030	-	2,001	491	644	16,288	15,482	26,138	1,256
ARKANSAS	41,494	11,016	24,868	-	4,410	409	686	18	-	-	87
CALIFORNIA	343,272	1,650	267,562	45,22[illegible]	229	1,637	5,890	-	-	-	10,279
COLORADO	46,062	-	21,671	3,865	1,493	561	630	-	15,137	-	2,704
CONNECTICUT	39,510	1,551	26,625	2,561	1,676	-	456	-	-	5,708	931
DELAWARE	30,364	744	5,504	1,175	364	695	355	-	-	19,931	1,597
DIST. OF COL.	77,844	10,009	10,569	1,677	2,388	1,543	167	12,032	9,588	24,968	4,482
FLORIDA	180,236	33,135	93,784	-	27,096	5,254	7,645	-	-	6,639	6,682
GEORGIA	100,825	515	71,978	7,499	4,282	1,282	7,142	-	-	-	8,128
HAWAII	136,253	4,502	11,171	1,298	2,323	800	6,686	12,398	2,488	94,251	338
IDAHO	14,612	295	8,472	1,570	533	206	477	-	3,059	-	-
ILLINOIS	82,810	2	71,421	-	1,782	381	4,230	-	-	-	4,995
INDIANA	31,625	1,826	25,448	-	1,520	1,322	1,539	-	-	-	171
IOWA	29,725	9,346	17,890	-	756	310	1,220	-	-	-	204
KANSAS	17,993	861	12,910	2,231	822	97	705	-	-	-	368
KENTUCKY	166,928	1,551	50,212	7,492	2,430	728	3,450	21,231	3,847	75,989	-
LOUISIANA	94,237	2,213	69,956	11,406	7,675	408	2,420	-	-	-	160
MAINE*	-	-	-	-	-	-	-	-	-	-	-
MARYLAND	401,927	11,428	41,592	5,418	6,365	1,614	54,572	21,617	21,547	214,044C	23,726
MASSACHUSETTS*	-	-	-	-	-	-	-	-	-	-	-
MICHIGAN	185,462	1,070	83,683	27,678	4,250	259	2,550	-	35,661	16,702	13,609
MINNESOTA	33,892	1,246	25,739	3,497	2,591	83	735	-	-	-	-
MISSISSIPPI	76,614	9,610	52,153	4,011	7,996	547	2,298	-	-	-	-
MISSOURI	60,580	334	36,386	8,535	2,511	679	1,967	71	-	9,952	146
MONTANA*	-	-	-	-	-	-	-	-	-	-	-
NEBRASKA	12,899	1,717	8,890	-	572	215	1,252	-	-	-	253
NEVADA	11,086	649	6,403	3,217	696	-	100	-	-	-	20
NEW HAMPSHIRE	11,504	665	7,881	2,033	618	298	8	#	-	-	-
NEW JERSEY	78,849	202	40,132	5,255	4,109	338	3,057	-	19,539	-	6,216
NEW MEXICO*	-	-	-	-	-	-	-	-	-	-	-
NEW YORK	340,264	2,008	133,538	4,380	3,935	1,174	15,653	-	-	107,002	72,575
NORTH CAROLINA	119,346	4,843	81,522	10,644	4,678	2,383	6,605	-	-	1,818	6,852
NORTH DAKOTA	7,730	267	6,953	-	327	110	73	-	-	-	-
OHIO*	-	-	-	-	-	-	-	-	-	-	-
OKLAHOMA	56,699	1,682	30,434	-	3,419	331	2,347	12,245	-	-	6,151
OREGON	23,419	685	19,993	-	1,269	53	131	-	-	-	1,338
PENNSYLVANIA	184,847	699	87,264	14,602	5,510	123	15,661	-	40,845	-	20,142
RHODE ISLAND	15,002	1,141	9,594	699	510	191	259	-	-	-	2,609
SOUTH CAROLINA	95,099	20,401	57,193	6,234	3,614	247	5,283	-	-	-	2,127
SOUTH DAKOTA*	-	-	-	-	-	-	-	-	-	-	-
TENNESSEE	96,048	6,842	64,758	8,058	6,708	3,209	3,113	177	-	-	3,183
TEXAS	211,983	8,221	107,264	37,627	12,463	2,598	8,590	-	-	15,026	20,196
UTAH	22,340	963	15,083	1,676	755	234	888	54	-	-	2,686
VERMONT	13,681	627	10,507	1,014	599	603	132	-	-	-	-
VIRGINIA	105,758	10,810	65,024	5,914	2,820	4,649	841	-	-	-	15,700
WASHINGTON	36,285	544	26,656	4,423	1,489	288	1,844	-	-	-	1,140
WEST VIRGINIA	120,685	1,858	20,754	1,699	864	583	39,797	253	3,171	41 66	2,959
WISCONSIN*	-	-	-	-	-	-	-	-	-	-	-
WYOMING	10,327	2,747	3,241	2,684	269	611	548	-	-	-	227
AMERICAN SAMOA*	-	-	-	-	-	-	-	-	-	-	-
GUAM*	-	-	-	-	-	-	-	-	-	-	-
PUERTO RICO	326,412	39,340	72,227	258	2,661	282	2,371	11,814	-	190,224	7,235
VIRGIN ISLANDS	51,639	-	6,562	241	94	-	-	170	482	43,635	454

* THE PUBLIC HEALTH AGENCIES IN MAINE, MASSACHUSETTS, MONTANA, NEW MEXICO, OHIO, SOUTH DAKOTA, WISCONSIN, AMERICAN SAMOA, AND GUAM DID NOT REPORT TO THE PUBLIC HEALTH FOUNDATION FOR FY 1984.

NOTE: THE DATA IN THIS TABLE RELATE ONLY TO EXPENDITURES OF OFFICIAL STATE HEALTH AGENCIES. THE PUBLIC HEALTH EXPENDITURES OF OTHER AGENCIES SUCH AS SEPARATE MENTAL HEALTH AUTHORITIES, ENVIRONMENTAL AGENCIES, AND HOSPITAL AUTHORITIES ARE NOT REFLECTED IN THE PUBLIC HEALTH FOUNDATION'S DATA BASE.

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SOURCE: PUBLIC HEALTH FOUNDATION, 1220 L STREET, N.W., SUITE 350, WASHINGTON, D.C. 20005.

1985

APPENDIX TABLE B STATE HEALTH AGENCY EXPENDITURES OF HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) GRANT AND CONTRACT FUNDS, BY AUTHORIZING STATUTE, FISCAL YEAR 1985

STATES AND TERRITORIES (1)	TOTAL HRSA GRANT AND CONTRACT FUNDS (2)	MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT (PL 97-35) (3)	FAMILY PLANNING (TITLE X, PHS ACT) (4)	MIGRANT HEALTH (SEC. 329, PHS ACT) (5)	NATIONAL HEALTH PLANNING & RESOURCES DEVELOPMENT ACT (PL 93-64 (6)	OTHER HRSA (7)
		(THOUSANDS OF DOLLARS)				
TOTAL	$528,863	$399,410	$68,350	$4,769	$12,990	$23,355
ALABAMA	13,072	9,580	3,420	•	•	73
ALASKA	1,265	847	•	•	•	399
ARIZONA	4,119	3,568	•	•	282	269
ARKANSAS	5,201	3,342	1,779	•	•	130
CALIFORNIA	21,692	21,163	•	•	•	529
COLORADO	9,762	5,055	1,046	1,046	222	2,392
CONNECTICUT	3,024	2,623	•	•	250	151
DELAWARE	2,069	1,631	439	•	•	•
DIST. OF COL.	5,643	5,593	•	•	•	49
FLORIDA	16,498	10,508	5,831	59	•	•
GEORGIA	15,883	11,931	3,953	•	•	•
HAWAII	3,658	1,866	729	•	462	601
IDAHO	3,440	2,588	725	•	259	68
ILLINOIS	12,285	6,997	4,273	•	717	298
INDIANA	6,920	6,266	•	•	419	235
IOWA	7,443	6,373	851	•	219	•
KANSAS	5,052	3,269	1,101	154	294	234
KENTUCKY	12,887	9,390	2,903	•	230	343
LOUISIANA	12,660	9,612	2,575	•	•	472
MAINE	3,471	2,295	1,176	•	•	#
MARYLAND	12,674	10,025	2,337	•	314	•
MASSACHUSETTS	11,012	10,874	•	•	21	118
MICHIGAN	19,676	15,372	4,279	•	•	25
MINNESOTA	7,202	7,114	•	•	88	•
MISSISSIPPI	10,614	6,760	2,910	•	•	944
MISSOURI	9,404	8,906	•	•	177	320
MONTANA	•	•	•	•	•	•
NEBRASKA	3,844	2,324	947	213	261	99
NEVADA	1,487	920	144	•	300	123
NEW HAMPSHIRE	2,469	1,782	614	•	•	102
NEW JERSEY	11,950	8,704	1,907	•	462	876
NEW MEXICO	4,676	3,303	1,142	•	227	4
NEW YORK	42,202	34,872	5,928	•	915	487
NORTH CAROLINA	18,804	14,131	4,260	315	•	99
NORTH DAKOTA	1,389	675	423	•	197	94
OHIO	21,711	17,406	2,995	17	674	619
OKLAHOMA	7,157	4,068	2,557	272	•	261
OREGON	5,880	4,679	1,201	•	•	•
PENNSYLVANIA	25,947	23,676	•	706	564	1,001
RHODE ISLAND	2,796	1,432	268	•	809	87
SOUTH CAROLINA	15,109	9,562	3,173	112	•	2,263
SOUTH DAKOTA	•	•	•	•	•	•
TENNESSEE	14,925	10,460	3,925	203	336	•
TEXAS	29,870	19,500	9,385	•	663	322
UTAH	5,744	5,329	•	•	279	154
VERMONT	2,172	1,698	443	•	211	•
VIRGINIA	14,955	11,563	3,057	•	335	•
WASHINGTON	8,695	6,287	2,161	•	15	231
WEST VIRGINIA	9,499	6,000	1,120	•	630	1,749
WISCONSIN	8,733	8,416	•	•	317	•
WYOMING	•	•	•	•	•	•
AMERICAN SAMOA	•	•	•	•	•	•
GUAM	•	•	•	•	•	•
PUERTO RICO	20,644	11,775	363	1,493	1,255	5,560
VIRGIN ISLANDS	2,747	1,120	342	•	75	1,210

• DATA HAVE BEEN ESTIMATED FOR THE SMAS IN AMERICAN SAMOA, GUAM, MONTANA, SOUTH DAKOTA, AND WYOMING, WHICH DID NOT REPORT TO THE PUBLIC HEALTH FOUNDATION FOR FISCAL YEAR 1985. ESTIMATED DATA HAVE BEEN INCLUDED IN THE UNDERLINED TOTALS.

NOTE: THE DATA IN THIS TABLE RELATE ONLY TO EXPENDITURES OF OFFICIAL STATE HEALTH AGENCIES. THE PUBLIC HEALTH EXPENDITURES OF OTHER AGENCIES SUCH AS SEPARATE MENTAL HEALTH AUTHORITIES, ENVIRONMENTAL AGENCIES, AND HOSPITAL AUTHORITIES ARE NOT REFLECTED IN THE PUBLIC HEALTH FOUNDATION'S DATA BASE.

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SOURCE: PUBLIC HEALTH FOUNDATION, 1220 L STREET, N.W., WASHINGTON, D.C. 20005

1985

APPENDIX TABLE 12. PERSONAL HEALTH PROGRAM EXPENDITURES OF STATE HEALTH AGENCIES, BY PROGRAM CATEGORY, FISCAL YEAR 1985

STATES AND TERRITORIES (1)	TOTAL PERSONAL HEALTH (2)	SUPPORTING PERSONAL HEALTH SERVICES (3)	MATERNAL AND CHILD HEALTH (4)	HANDICAPPED CHILDREN'S SERVICES (5)	COMMUNICABLE DISEASE CONTROL (6)	DENTAL HEALTH (7)	CHRONIC DISEASE (8)	MENTAL HEALTH (9)	ALCOHOL & DRUG ABUSE (10)	EMA-OPERATED INSTITUTIONS (11)	OTHER PERSONAL HEALTH (12)
					(THOUSANDS OF DOLLARS)						
TOTAL	$5,000,636	$240,473	$2,290,178	$280,274	$181,662	$47,490	$256,835	$109,444	$242,445	$1,074,319	$297,499
ALABAMA	53,898	1,588	46,519	•	4,635	373	731	•	•	•	52
ALASKA	19,765	11,493	3,896	1,952	1,825	•	•	•	•	•	•
ARIZONA	91,571	2,690	23,139	•	1,587	596	773	17,535	13,105	31,005	1,141
ARKANSAS	46,578	7,818	32,677	•	4,859	390	713	61	•	•	81
CALIFORNIA	301,864	4,699	219,591	44,573	13,163	2,032	5,893	•	•	•	11,913
COLORADO	48,663	•	22,625	4,143	1,751	581	615	•	16,401	•	2,769
CONNECTICUT	40,247	1,928	26,808	2,298	2,002	•	573	•	•	5,708	929
DELAWARE	33,802	714	6,205	1,248	430	738	589	•	•	22,323	1,755
DIST. OF COL.	90,196	10,424	13,980	1,407	3,367	1,707	243	14,334	14,429	25,580	4,524
FLORIDA	159,696	4,396	116,344	•	18,505	6,130	6,576	•	•	5,829	4,096
GEORGIA	102,894	556	73,631	6,979	4,643	1,264	6,298	•	•	•	9,523
HAWAII	145,015	4,625	12,345	1,434	2,458	835	6,571	12,847	2,696	100,628	376
IDAHO	16,284	278	9,825	1,853	608	241	493	•	2,987	•	•
ILLINOIS	85,744	6	73,751	•	2,051	395	4,795	•	•	•	4,746
INDIANA	38,056	1,691	31,279	•	1,771	1,285	1,924	•	•	•	107
IOWA	33,666	10,326	20,819	•	809	275	1,186	•	•	•	250
KANSAS	18,748	749	13,310	2,387	805	93	255	•	•	•	1,150
KENTUCKY	66,886	1,373	51,701	7,495	2,816	731	2,770	•	•	•	•
LOUISIANA	96,828	1,615	72,652	12,485	7,329	340	2,260	•	•	•	147
MAINE	15,288	1,660	10,828	1,100	371	343	925	•	37	•	24
MARYLAND	490,922	12,329	42,973	7,048	7,438	1,595	70,569	25,409	24,941	274,190	24,431
MASSACHUSETTS	209,780	6,495	40,660	3,924	8,861	2,716	398	•	39,544	95,686	11,689
MICHIGAN	198,544	1,959	88,715	28,799	4,425	198	2,368	•	37,948	18,227	15,906
MINNESOTA	42,548	1,120	28,246	4,579	1,154	108	965	•	•	•	6,396
MISSISSIPPI	79,679	11,182	53,991	4,212	7,701	607	1,985	•	•	•	•
MISSOURI	67,064	387	40,697	10,180	3,357	637	2,033	81	•	9,341	172
MONTANA	•	•	•	•	•	•	•	•	•	•	•
NEBRASKA	14,318	1,958	10,063	•	604	230	1,213	•	•	•	250
NEVADA	11,489	719	6,704	3,202	732	•	113	•	•	•	19
NEW HAMPSHIRE	13,032	361	9,171	1,961	884	353	282	•	•	•	•
NEW JERSEY	81,315	341	40,235	5,307	4,209	448	3,236	•	20,455	•	7,084
NEW MEXICO	127,328	964	21,443	3,872	1,819	430	10,193	14,351	12,717	54,358	7,181
NEW YORK	368,860	2,410	159,534	2,969	6,400	1,159	12,818	287	•	118,808	64,434
NORTH CAROLINA	128,926	3,262	91,366	12,013	5,044	2,817	6,322	•	•	2,044	6,077
NORTH DAKOTA	7,134	346	6,155	•	660	73	100	•	•	•	•
OHIO	123,963	4,102	83,646	18,164	4,425	1,222	1,644	•	10,149	•	609
OKLAHOMA	57,833	1,951	30,815	•	3,700	265	2,633	10,720	•	•	7,748
OREGON	23,199	483	20,062	•	1,455	41	•	•	•	•	1,137
PENNSYLVANIA	197,940	711	92,990	17,106	8,194	121	*7,659	•	41,114	•	20,046
RHODE ISLAND	13,458	1,199	10,178	878	698	200	271	•	•	•	35
SOUTH CAROLINA	108,604	31,057	57,342	6,840	4,535	304	5,048	•	•	•	3,279
SOUTH DAKOTA	•	•	•	•	•	•	•	•	•	•	•
TENNESSEE	104,835	5,710	71,533	7,494	6,102	3,316	3,215	131	•	•	7,253
TEXAS	216,096	8,586	123,344	28,571	11,538	2,383	10,262	•	•	17,091	14,339
UTAH	23,885	831	16,428	1,774	787	254	913	53	•	•	2,846
VERMONT	14,868	612	11,365	1,121	783	475	112	•	•	•	•
VIRGINIA	127,210	12,682	66,476	6,624	2,548	5,748	1,386	•	•	•	31,744
WASHINGTON	40,911	724	28,692	7,053	1,531	379	975	•	•	•	1,557
WEST VIRGINIA	121,951	851	21,741	2,050	942	561	33,004	347	3,667	56,414	2,594
WISCONSIN	37,717	177	25,533	•	899	•	2,242	•	•	•	8,866
WYOMING	•	•	•	•	•	•	•	•	•	•	•
AMERICAN SAMOA	•	•	•	•	•	•	•	•	•	•	•
GUAM	•	•	•	•	•	•	•	•	•	•	•
PUERTO RICO	352,419	49,850	80,359	156	3,061	253	1,812	12,991	•	196,938	7,020
VIRGIN ISLANDS	43,269	19	6,300	216	132	•	104	248	1,058	34,096	1,096

* DATA HAVE BEEN ESTIMATED FOR THE SEAS IN AMERICAN SAMOA, GUAM, MONTANA, SOUTH DAKOTA, AND WYOMING WHICH DID NOT REPORT TO THE PUBLIC HEALTH FOUNDATION FOR FISCAL YEAR 1985. ESTIMATED DATA HAVE BEEN INCLUDED IN THE UNDERLINED TOTALS.

NOTE: THE DATA IN THIS TABLE RELATE ONLY TO EXPENDITURES OF OFFICIAL STATE HEALTH AGENCIES. THE PUBLIC HEALTH EXPENDITURES OF OTHER AGENCIES SUCH AS SEPARATE MENTAL HEALTH AUTHORITIES, ENVIRONMENTAL AGENCIES, AND HOSPITAL AUTHORITIES ARE NOT REFLECTED IN THE PUBLIC HEALTH FOUNDATION'S DATA BASE.

STANDARD SYMBOLS: • = ZERO OR NO DATA; # = LESS THAN 0.5 PERCENT OR LESS THAN $500, E = ESTIMATED BY THE RESPONDENT; U = DATA REPORTED AS UNOBTAINABLE BY THE RESPONDENT; C = DATA FOR THIS ITEM WAS COMBINED WITH REPORTING OF ANOTHER ITEM.

SOURCE: PUBLIC HEALTH FOUNDATION, 1220 L STREET, N.W., WASHINGTON, D.C. 20005